CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED D'RING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber, M.D. Title: Commissioner of Health Date: 3/28/63

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C. P. Force — Records Management Officer — Date: 3/28/63

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR — Hyman C. Zysow

2. APPROVED: CITY SOLICITOR — Thomas N. Biddison

3. APPROVED: CITY COMPTROLLER — Hyman A. Pressman

4. APPROVED: CITY TREASURER — John E. Mowling

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS — Bernard Feldman

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM — W. T. Hunter

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE — Carl N. Hunter

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59673

E 59673

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Garrison Blvd. WARD 15-61

2-FULL NAME August Edward Greupler

(a) RESIDENCE NO. 2311 Garrison Blvd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret L.

DATE OF BIRTH (month, day, and year) Sept 17 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	10	22	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Charles Greupler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Loretta Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret L. Greupler

(Address) 2311 Garrison Blvd

Filed AUG 11 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Colvin Smith, M. D. Coroner

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Aug 11 1930

20 UNDERTAKER Wm J Tuckner Sons

ADDRESS N Y Pa

c.—1-30—M. & T.—250 Bks.

E 39173 E 59674

HEALTH DEPARTMENT—CITY OF BALTIMORE

135 E 59674

JOHNS HOPKINS HOSPITAL

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16-67 ST., WARD)

2-FULL NAME Charles Purdy

(a) RESIDENCE NO. 2946 Freshman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced (HUSBAND of or) WIFE of: Lillie D. Purdy

DATE OF BIRTH (month, day, and year): Mar. 6, 1863

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: John Purdy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Jane Isles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

Informant (Address): Relative JOHNS HOPKINS HOSPITAL

Filed AUG 11 1930, [illegible] JOHNS, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10-1930

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to Aug 10, 1930, that I last saw him alive on Aug 10, 1930, and that death occurred, on the date stated above, at 7 25 a m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Hernia

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil F. Cabada, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Aug 12 1930
20 UNDERTAKER	ADDRESS
Wm. F. Kerr & Sons	North & Pa

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ **E 59675**

59675 REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1030 Brentwood ST. 10-16 WARD) Agnes Bernadine Harrison-BELL

2—FULL NAME 1030 Brentwood ST., WARD

(a) RESIDENCE NO. (Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) June 2nd 1875

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	55	2	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Manchester England

30 NAME OF FATHER: Andrew Rochford

31 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

32 MAIDEN NAME OF MOTHER: Ann Galvin

33 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Geo. J. Harrison (Son)

(Address): 1030 Brentwood Ave

Filed: DEC 1 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5, 19 30, to Aug 9, 19 30

that I last saw h ... alive on Aug 9, 19 30

and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

Edema Lungs

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Thos. F. Stevens, M. D.

8/13 19 30 (Address) 2878 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Baltimore Co. DATE OF BURIAL: Aug 13 1930

20 UNDERTAKER: Edmund W. Conklin ADDRESS: 924 E. Eager St

c.—1-30—M. & T.—250 Bks

59676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 90 ✓ E 59676

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST. 26-37 WARD)

2-FULL NAME George Willis. (Negro)

(a) RESIDENCE NO. Turney's Station ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Willis

DATE OF BIRTH (month, day, and year) Aug 23 - 1877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53?	11	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel.

BIRTHPLACE (city or town) (State or country) Robinson County N. C.

10 NAME OF FATHER Sam'l Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Nancy Purcell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

Informant Records of.

(Address) BALTIMORE CITY HOSPITALS

Filed 11 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to Aug. 9, 1930, that I last saw h.. alive on Aug. 9, 1930, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

8-10, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkton, Md.

DATE OF BURIAL Aug 13 1930

20 UNDERTAKER Sam'l. Wise Son

ADDRESS Woodlawn.

c.—1-30—M. & T.—250 Blks

59677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 E 59677

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 5-E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.

2-FULL NAME Herbert Mitchell

(a) RESIDENCE NO. 1234 E. Fayette st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 12, 1888

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
41	10	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

BIRTHPLACE (city or town) (State or country) South Carolina

10 NAME OF FATHER Peter Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

Informant Hospital Records

(Address)

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to Aug. 7, 1930, that I last saw him alive on Aug. 7, 1930, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculous enteritis with peritonitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Turner, M. D.

8-7-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL aug 11 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1681 orleans st

8-16-29—L. F. S.—100 Bks.

59678 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 113 E 59678

CERTIFICATE OF DEATH

REGISTERED NO. 25-77

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Vincents Infant ~~Hospital~~ WARD)

2—FULL NAME Daniel Walter Neuheimer

(a) RESIDENCE NO. 1611 Cherry St ST., Curtis Bay WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Infant

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 3 1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	1	2	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Mother

(Address) 1611 Cherry St.

Filed Aug 12, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to Aug 9, 1930, that I last saw h im alive on Aug 7, 1930 and that death occurred, on the date stated above, at 1 P.M. m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clennell Howell, M. D.

, 19 (Address) 101 Richmond St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Aug 11 1930 DATE OF BURIAL

20 UNDERTAKER F W Gazdebski ADDRESS 1930 Eastern

30—M. & T.—100 B—50L

E 59679

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59679

CERTIFICATE OF DEATH

REGISTERED NO. 188-103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq Hosp ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Rawlins

(a) RESIDENCE NO 1236 Glyndon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Ann Rawlins

DATE OF BIRTH (month, day, and year) Mar 5 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 050
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lithuania

10 NAME OF FATHER Jos Rawlins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Eva Lukte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant M. Rawlins

(Address) 406 S. Poca St.

15 Filed 1-1 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 88 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: While Crossing D & C Bridge on Monroe St was struck struck down & mortally inj

(a) (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? D & C Bridge on Monroe St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

8 (Signed) L Frauen, M. D. Coroner

11, 1930 (Address) 2129 W Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 12 1930
20 UNDERTAKER	ADDRESS
John Grebhäuser	423 S Poca

Spec.—1-10-21—M&T—1500 Blks.

E 59680

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59680

REGISTERED NO. 25-72 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3401 (St.) Metkus Ave (WARD) 25

2-FULL NAME Eugene R. McCrea

(a) RESIDENCE NO. above ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Dec 5 - 1853

7 AGE: Years 76; Months 8; Days 3; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jos. A McCrea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Eliza B Crosdale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs. J. McCaffrey 3401 Metkus Ave

15 Filed: 1.1.1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 8 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1928, to Aug 8, 1930.

that I last saw him alive on Aug 8, 1930

and that death occurred, on the date stated above, at 1, P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos 38 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. A. Knell, M. D.

(Address) Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery DATE OF BURIAL: Aug 11 1930

20 UNDERTAKER: George L. Schwartz ADDRESS: 2101 Eutaw Ave.

c—1-30—M. & T.—250 Bks.

E 59681 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59681

CERTIFICATE OF DEATH.

REGISTERED NO. 74-004

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4813 Belair Road (St.) 26-47 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Humeke

(a) RESIDENCE NO. 4813 Belair Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Humeke

6 DATE OF BIRTH (month, day, and year) Jan. 6 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

10 NAME OF FATHER Edward D. Humeke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Alice Hohlingbrieg

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

Informant Augusta Humeke

(Address) 4813 Belair Rd.

Filed 1-1 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/30.

17 I HEREBY CERTIFY, That I attended deceased from 8/2/30, to 8/9/30, 1930

that I last saw him alive on 8/9/30, 1930

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Hemorrhage brain

9 hours

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed C. D. Corse, M. D.

(Address) Corse & Southern

8/9/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Aug. 12, 1930
20 UNDERTAKER	ADDRESS
Fredk. Loseman Sons	3401 Belair Rd.

...c. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59682

CERTIFICATE OF DEATH

105 E 59682

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 723 W. Cross ST. (WARD) 7-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles A. Hamilton

(a) RESIDENCE NO. 723 W Cross ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Esbett V. Hamilton

6 DATE OF BIRTH (month, day, and year) Dec 26/1872

7 AGE	Years	Months	Days	(If LESS than 1 day, hrs. or min.
	57	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) R. R. 42

(c) Name of employer B & O

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Wm A. Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Charles A. Hamilton

(Address) 723 W Cross

Filed ... 19 ... Registrar

A T 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10/30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Aug 10, 1930

that I last saw him alive on Aug 10, 1930

and that death occurred, on the date stated above, at 8-45 P.m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

8/10, 1930 (Address) 1644 Harwood Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 8/13 1930

20 UNDERTAKER Geo A Tinley

ADDRESS Balto & Fayette

c.—1-30—M. & T.—250 Bks.

86-002

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59683

CERTIFICATE OF DEATH.

E 59683

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

TY OF BALTIMORE: (No. Caroline & Eliza Sts ST. 27-42 WARD)

2-FULL NAME Edward Robert

(a) RESIDENCE NO. 5872 Belair Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Anna M. Robert

DATE OF BIRTH (month, day, and year) Oct 17 1890

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	9	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor & Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sarah Janeway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Anna M. Robert

(Address) 5846 Belair Rd.

Filed 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Aug 2, 1930,

that I last saw him alive on Aug 2, 1930,

and that death occurred, on the date stated above, at 3 40P m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Eczema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 2 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vincent Keating, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 13, 1930
20 UNDERTAKER	ADDRESS
Frederick Lassahn & Sons	7401 Belair Rd.

c—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59684 — CERTIFICATE OF DEATH — 49 — E 59684

1—PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 2109 Hollins ST. 70-69 WARD)

2—FULL NAME Henry H. Burns

(a) RESIDENCE NO. 2109 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or (town and State)

gth of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

f married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) Oct 2, 1862

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
8		10	1	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 31

(c) Name of employer

IRTHPLACE (city or town) (State or country) Maryland

0 NAME OF FATHER Henry Burns

1 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

2 MAIDEN NAME OF MOTHER [illegible]

3 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant _____

(Address) 2109 Hollins

Filed _____, 19__ _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1929, to Aug 8, 1930

that I last saw him alive on Aug 6, 1930

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 11 mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H. Keeley M. D.

8 Aug 1930 (Address) 1729 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Loudon Park~~ National	Aug 12 1930
UNDERTAKER Leo A. Farley	ADDRESS 1800 W. Fayette

ec.—1-12-23—M&T—500 Bks.

Galeon

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

59685

E-59685

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 628 N. Central ST., 5-6 WARD)

2-FULL NAME Emma Galeon

(a) RESIDENCE NO. 628 N. Central ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of X

DATE OF BIRTH (month, day, and year) July 3rd 1886

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
34		1	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O.H.D.

(b) General nature of industry, business, or establishment in which employed (or employer) Common Labor.

(c) Name of employer X X

BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Viola Walker

(Address) 1625 N. Carrollway

Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-28 1930 to 8/8 1930

that I last saw h alive on 8/6 1930

and that death occurred, on the date stated above, at 6 40 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Acute Endocarditis

(duration) 6 days

CONTRIBUTORY (Secondary) Colds & Fever

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

Signed James R. Blake M. D.

(Address) 24 Forsyth St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedarcroft	Aug 11 1930
20 UNDERTAKER Mrs. Ida Saunders	ADDRESS 1708 E. Madison

HERBERT J. JONES, M. D.

FILED

E.59686

30—M. & T.—100 B—50L

E.59686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. J. H. Hospital ST. J-11 WARD)

2-FULL NAME Alice Mary Bosse

(a) RESIDENCE No. 515 N. Decker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of .....

DATE OF BIRTH (month, day, and year) July 28, 1929

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	0	9	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Leo E. Bosse

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Verna Spann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Leo E. Bosse

(Address) 515 N. Decker Ave.

15 Filed ..... 193 ..... A. M. ..... Registrar .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Rickets

(duration) yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? 515 N. Decker

Did an operation precede death? — Date of —

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis? Autopsy

(Signed) J. C. Gladden, M. D. Coroner

19 (Address) 43 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dist. Federal Cemetery

DATE OF BURIAL 8/11 19 30

20 UNDERTAKER E. D. Pennington

ADDRESS 1936 E. Lafayette

c.—1-30—M. & T.—250 Bks.

Frank Lorek

E 59687

59687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (NO. Church Home & Infirmary ST. WARD)

2-FULL NAME Mr. Frank Lorek

(a) RESIDENCE NO. 1712 Alice Anna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced HUSBAND) of ~~or WIFE of~~ Bronslwa Lorek

DATE OF BIRTH (month, day, and year) September 27 1871.

AGE	Years	Months	Days	If LESS than 1 day, ? hrs. or ? min.
	58	10	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Poland.

10 NAME OF FATHER Frank Lorek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Agnes Poland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Andrew Lorek 1712 Alice (Address) Anna St.

Filed Aug 13 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Aug 10, 1930, that I last saw h. alive on Aug 10, 1930, and that death occurred, on the date stated above, at 2.40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Purulent Peritonitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Bronchio - pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home Infirmary

Did an operation precede death? Yes Date of Aug 3-1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Physical Operation

(Signed) J. Frank Hewitt M. D.

Aug 3, 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery — DATE OF BURIAL Aug 13 1930

20 UNDERTAKER George A. Weber 708 E. Ann St. — ADDRESS

c.—1-30—M. & T.—250 Bks.

E 35~~3~~9~~6~~8~~8~~7 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59638

CERTIFICATE OF DEATH. 139

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OR BALTIMORE: (No.) ST. 10-14 WARD)

2-FULL NAME Elizabeth Norman

(a) RESIDENCE NO. 1020 Wilcox ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): unknown

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Oct-30-1890

AGE: Years 39 40; Months 9; Days 9; If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Service Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (City or town) (State or country) S.C

10 NAME OF FATHER Wade Spearman

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Ellen Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 1-1 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9-1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to Aug 9, 1930, that I last saw her alive on Aug 9, 1930, and that death occurred, on the date stated above, at 8 15 a m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction with ileostomy

Marasmus Lung abscess

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of July 11 & July 25

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. L. Everett, M. D.

8/9, 1930 (Address) The Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem.

DATE OF BURIAL Aug 12 1930

20 UNDERTAKER J. Frow Wright 1218 Pine & Cherry St

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

E 59689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

145-003

E 59689

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 21-31 WARD)

2-FULL NAME Hattie Williams Gamble

(a) RESIDENCE NO. 1108 Russel ST ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced (or) WIFE of Thomas Gamble

6b DATE OF BIRTH (month, day, and year) ?

7 AGE Years 39 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Ben Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Husband 1108 Russel St

15 Filed AUG 11 1930 H. H. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 7, 1930, that I last saw her alive on Aug 7, 1930, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Prolonged Labor

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Heart Dilatation of (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical history, Phys. exam

(Signed) George N. Jeans, M. D.

11, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug 11 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59690 E 59690

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 240 Bowers St (Ward) 18-2a
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Preston Woods

(a) RESIDENCE NO. 240 Bowers St., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Single
If married, widowed, or divorced (or) WIFE of HUSBAND of

6 DATE OF BIRTH (month, day, and year) Dec 12 1902

7 AGE: Years 27 Months 7 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Prince George Co Md

10 NAME OF FATHER: Richard Woods

11 BIRTHPLACE OF FATHER (City or town) (State or country): Prince George Co Md

12 MAIDEN NAME OF MOTHER: Leanne Owens

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Anne Arundel Co Md

Informant: Leanne Davis
(Address) 215 N Stricker St

Filed AUG 11 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to Aug 8, 1930, that I last saw h[illegible] alive on Aug 8, 1930, and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Endocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Howell M. D.

1930 (Address) 601 W Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery
DATE OF BURIAL: Aug 12 1930

20 UNDERTAKER: Mrs Katie R Williams
ADDRESS 322 N Schroeder St

c.—1-30—M. & T.—250 Bks

59691 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59691

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001

1-PLACE OF DEATH Baltimore City Hospitals

TY OF BALTIMORE: (NO. ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Conyer (Connier)

(a) RESIDENCE NO. 1024 Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

If married, widowed, or divorced HUSBAND of or) WIFE of -

DATE OF BIRTH (month, day, and year) Unknown

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Unk

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant (Address) Records of Balto. City Hospitals

Filed 1 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3-30

17 I HEREBY CERTIFY, That I attended deceased from 8-4-30, 19..., to 8-3-30, 19...,

that I last saw her alive on 8-3-30, 19...,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Hypertension (duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diag.

(Signed) Paul Padgett, M. D.

8-9, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug 13 1930

20 UNDERTAKER Mrs Kate R. William

ADDRESS 322 [illegible]

30—M & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59692

CERTIFICATE OF DEATH

1927

E 59692

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 234 N. Bruce ST., WARD)

2-FULL NAME Susan Naylor

(a) RESIDENCE NO. 234 N. Bruce ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	—	—	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Md
(State or country)

10 NAME OF FATHER Isaac Butler

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Jane Walters

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant Bella Coleman

(Address) 234 N. Bruce

Filed 8 11 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest find that said deceased came to her death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows: Heat Prostration 9 days

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. W. Brooke, M. D. Coroner

8/8, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug 11 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 522 N. Schroeder St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59693

E 59693

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hollins Market. St., 14-28 Ward

2-FULL NAME Joseph L. Weaver.

(a) RESIDENCE NO. 1412 Hollins St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 8, 1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54	4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boiler maker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Weaver.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Marthe E. Turner.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mary C. Weaver. (sister)
(Address) 1412 Hollins St.

15 FILED 8 11 1930 C. HAYWARD JONES, M. D. Registrar
By R P K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Heat Prostration.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

8/11 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug 12 1930

UNDERTAKER George J. Smith

ADDRESS 1732 Hollins

c.—1-30—M. & T.—250 Blks

E 59694 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59694

CERTIFICATE OF DEATH. X 118

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) Provident Hospital (Ward) 14-20

2-FULL NAME Louisa Hadnay

(a) RESIDENCE NO. Manokin Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

married, widowed, or divorced
HUSBAND of
or) WIFE of Jenkins

ATE OF BIRTH (month, day, and year) Jenkins

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
72			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

IRTHPLACE (city or town) (State or country) Howard Co. Md.

10 NAME OF FATHER John Howard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Geo R Bowden

(Address) Rockville Md.

Filed 1930, 19 C. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11-30

17 I HEREBY CERTIFY, That I attended deceased from 8-4-, 1930, to 8-11-, 1930

that I last saw h alive on 8-11, 1930

and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows: Cerebral Thrombosis

Cerebral Hemorrhage

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8/10/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M Carlson, M. D.

11, 1930 (Address) Brookeville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Sandy Spring Md

UNDERTAKER Geo R Bowden

DATE OF BURIAL 8-13 1930

ADDRESS Rockville Md

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59695

CERTIFICATE OF DEATH

182 E 59695

1-PLACE OF DEATH

REGISTERED NO.

City of Baltimore: (No. St. Joseph Hospital St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Kabachnick

(a) RESIDENCE NO. 101 N. Exeter St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Eva Kabachnick

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tinner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Kabachnick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Dena ----------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jos. Sandel
(Address) 101 N. Exeter St.

15 Filed [illegible] 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10th 192 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and (from the evidence obtained by said Inquiry (inquest, autopsy or inquiry) find that said deceased came to Acc death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acc Fall from Roof
Fracture of Skull
(Duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 101 N Exeter St

Did an operation precede death? Yes Date of Aug 9/30

Was there an autopsy?

What test confirmed diagnosis? Oper

(Signed) J. C. Wades M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Rd DATE OF BURIAL 8-11- 1930

20 UNDERTAKER Jacob Fairs ADDRESS 1431 E Baltimore St.

e—1-12-29—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59696

CERTIFICATE OF DEATH.

100-001

E 59696

1-PLACE OF DEATH Hebrew Home for Aged & Infirm REGISTERED NO.

ITY OF BALTIMORE: (No. Belvedere & Greenspring Ave. ST. 71-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Siegel

(a) RESIDENCE NO. Belvedere & Greenspring Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: MALE

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie

DATE OF BIRTH (month, day, and year)

AGE: 54 Years Months Days If LESS than 1 day, hrs or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Abram

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant

(Address)

Filed 1-1 1930 H. [illegible] JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to August 10, 1930, that I last saw him alive on August 10, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Edmund Levin, M. D.

, 19 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen Circle, Mt. Carmel | DATE OF BURIAL: 8-12 1930

20 UNDERTAKER: Isaac Levine | ADDRESS: 1439 E. Baltimore St.

Dec.—8-16-29—L. F. S.—100 Bks.

59697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-081 E 59697

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 S. Rose ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew (Bednar) Cooper

(a) RESIDENCE NO. 804 S. Rose St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth (Bednar) Cooper

DATE OF BIRTH (month, day, and year) aug 5 1856

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74		6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer Spotless Stove Co

BIRTHPLACE (city or town) (State or country) Czecho Slovakia

10 NAME OF FATHER Andrew (Bednar) Cooper

11 BIRTHPLACE OF FATHER (city or town) Czecho (State or country) Slovakia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Czecho (State or country) Slovakia

Informant Elizabeth (Bednar) Cooper

(Address) 804 S. Rose St. ~~M. D.~~

Filed Aug 12 1930 19 RMC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 9, 1930, that I last saw h— alive on Aug 9, 19..., and that death occurred, on the date stated above, at 815 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. Frank L. Jamison M. D.

8/11/30 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Aug 12 1930

20 UNDERTAKER Stephen J. Fialkowski

ADDRESS 1000 E. Kenwood ave

Cor.—10-10-29—A Co.—100 Bks.

E 59698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74001 ✓

E 59698

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5309 Hadden Ave St. 28-63 Ward)

2-FULL NAME Elizabeth C. Miller

(a) RESIDENCE NO. 5309 Hadden Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of William Miller

6 DATE OF BIRTH (month, day, and year) Nov. 12 - 1862

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or ... min.
	67.	8	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Herman Beste.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant William Miller
(Address) 5309 Hadden Ave

15 Filed ..., 19... Ellen Jones, Asst. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to free death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Sudden
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home,

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Feick, M. D. Coroner

(Address) Aug 10

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Aug 12 1930
20 UNDERTAKER	ADDRESS
Josiah Syfer	[illegible]

c.—1-30—M. & T.—250 Bks.

59699 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59699

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 N Broadway St. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis A. Hazard

(a) RESIDENCE NO. 1738 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda V. [Cullison]

DATE OF BIRTH (month, day, and year) 8-15-1852

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	11	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mgr.

(b) General nature of industry, business, or establishment in which employed (or employer) Wm Bros. & Co

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Louis A. Hazard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emaline Hazard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mary Hazard

(Address) 1738 N. Broadway

Filed 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7-1930

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to Aug 9, 1930,

that I last saw h. alive on Aug 9, 1930,

and that death occurred, on the date stated above, at 5:1 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Following Cerebral Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Hampson Jones, M. D.

8-11-1930 (Address) 117 W. Hamilton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL 8/12/30

20 UNDERTAKER George D. Puth Inc

ADDRESS 1751 Harford

ec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59700

E 59700

CERTIFICATE OF DEATH.

X 45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp ST. 6-6X WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Caroline W. Frentz.

(a) RESIDENCE NO. 112 Osborne Ave. (Catonsville) Md.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

(If married, widowed, or divorced) (HUSBAND of or) WIFE of Henry A Frentz

DATE OF BIRTH (month, day, and year) Oct 3 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	10	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto Md.

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town): "

(State or country) "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town): "

(State or country) "

14 Informant: Henry A Frentz

(Address) 112 Osborne Ave. Catonsville Md.

15 Filed: 1 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/30, 1930, to Aug 9, 1930, that I last saw h W alive on Aug 9, 1930, and that death occurred, on the date stated above, at 8.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Carcinomatosis

Unknown (duration) yrs mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Aug. 5, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. Ashburn M. D.

19 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 8-12 1930

20 UNDERTAKER: Mc Chas A Gr Robd 2327 Edmondson Ave — ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

E 59701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59701

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hosp. St., 33 E. Ward)

2-FULL NAME Edward Bowman

(a) RESIDENCE NO. 40 & 42 Keswick Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	W.	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
42 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundry
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Dorothy Poline
(Address) 344 Hanover Road

15 Filed 1930 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wound
Through the head
Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Mowbray Jr. M. D.

Aug 19, 1930 (Address) 7672 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

THE MORGUE

AUG 11 1930
JOHNS HOPKINS HOSPITAL

30—M. & T.—100 B—50L

E 59702

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59702

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1516 Brunt ST. 14-20 (WARD)

2-FULL NAME Wm Harris

(a) RESIDENCE NO. 1516 Brunt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of no

DATE OF BIRTH (month, day, and year) 1892

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) W. Va.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elkins

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ollie Richy (Address) 1516 Brunt.

15 Filed ..... 1930 ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Aortic Insufficiency

(duration) Several Months

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Regular.

What test confirmed diagnosis? H. Fink, M. D.

(Signed) Coroner

Aug 5th 1930 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL AUG 11 1930

20 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M.D. Commissioner Health.

JOHNS HOPKINS HOSPITAL

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59703

E 59703

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 76-37 Ward)

2-FULL NAME Mary Snead

(a) RESIDENCE NO. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary 2nd attack
Fatal period 3 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James W. Fenton M. D.

8/4 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19 AUG 11 1930
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Department of Municipal Health.
MORGUE

30—M. & T.—100 B—50L

E 59704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59704

REGISTERED NO. 160

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 666 Vine ST. H-25 WARD)

2-FULL NAME Clarence Roberts

(a) RESIDENCE NO. 666 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2		

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Clarence Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

Informant

(Address)

Filed , 192 Registrar

1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D. Coroner

8/8, 1930 (Address) 2709 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL AUG 11 1930 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M. D. Commissioner Health.

1-30—M. & T.—250 Bks.

E 59705 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59705

100-00

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hosp. (10-14 WARD)
CITY OF BALTIMORE: (No. ..... ST.)

2-FULL NAME Lena Haynesworth

(a) RESIDENCE NO. 940 Hanford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
[illegible]	Colored	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of David Haynesworth

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) ? 0

(c) Name of employer ?

BIRTHPLACE (city or town) Greenville
(State or country) South Carolina

10 NAME OF FATHER Samuel Gaines

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Caroline Hodges

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

Informant Husband.
(Address) Balto City Hosp.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3-30

17 I HEREBY CERTIFY, That I attended deceased from 7-22, 1930, to 8-3, 1930, that I last saw h[illegible] alive on 8-3-, 1930, and that death occurred, on the date stated above, at 7½ P m.

The CAUSE OF DEATH* was as follows:

Uterine fibroid

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? yes Date of 8-1-30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Howard M. Dorsett, M. D.

19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
C. HAMILTON JONES, M. D.
Director of Public Health
AUG 14 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59706

CERTIFICATE OF DEATH

129

E 59706

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 612 S. Lehigh St. No 37 Ward)

2-FULL NAME Victor Killman

(a) RESIDENCE NO. 612 S. Lehigh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) June 28/1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Contractual
(c) Name of employer Con Co

9 BIRTHPLACE (city or town) Annapolis
(State or country)

PARENTS

10 NAME OF FATHER unknown Killman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Mrs Minnie Cachlen
(Address) 612 S Lehigh St

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

8/8/1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 8/12 1930

20 UNDERTAKER Wilson Cook

ADDRESS 1214 Eutaw St

ANDERSON JONES, M. D.

AUG 1930

ACS

c.—1-30—M. & T.—250 Blks

E 59707 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59707

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.

2-FULL NAME Emma Griswald.

(a) RESIDENCE NO. 1810 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of George Griswold

UNKNOWN.

DATE OF BIRTH (month, day, and year) UNKNOWN 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Co. Md

10 NAME OF FATHER UNKNOWN.

11 BIRTHPLACE OF FATHER (city or town) (State or country) UNKNOWN

12 MAIDEN NAME OF MOTHER UNKNOWN

13 BIRTHPLACE OF MOTHER (city or town) (State or country) UNKNOWN

Informant Records of BALTIMORE CITY HOSPITALS

(Address)

Filed 1-1930, 19 Registrar

L. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9, 1930

17

I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to Aug. 9, 1930,

that I last saw her alive on Aug 9, 1930,

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

more than 2 mos ds.
(duration) yrs.

CONTRIBUTORY (Secondary) Hypertension and arteriosclerosis (duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

8-10, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnson's	8/12 1930
20 UNDERTAKER	ADDRESS
W. M. Cook	1217 E. Lord St

c.—1-30—M. & T.—250 Bks.

E 59708

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59708

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 1238 E Fayette St. ST.) 5-8 (WARD)

2-FULL NAME Henry Lederer.

(a) RESIDENCE NO. 1238 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

If married, widowed, or divorced (HUSBAND of or) WIFE of Rachael Lederer.

DATE OF BIRTH (month, day, and year) July 16 1857.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	-	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit dealer.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Michael Lederer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva M. Strattner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Katherine Leddenine

(Address) 2903 N Calvert

Filed 1930 19 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1930 to Aug 10 1930

that I last saw h[illegible] alive on August 9 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Pharynx and Larynx

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? None Date of

Was there an autopsy? none

What test confirmed diagnosis? None

(Signed) Richard C Evelyn M. D.

19 (Address) 514 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 12 1930

20 UNDERTAKER Wm Cook. — ADDRESS 1217 St Paul.

Spec. 7-17-26—A Co.—200 Bks.

E 59709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E. 59709

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3708 Chesholm Rd St. 16-66 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Fallion

(a) RESIDENCE NO. 3708 Chesholm Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1, 1844

7 AGE: Years 86 Months 3 Days 10 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jacob Bushey

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mrs. Sarah Fleyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Mrs. E. E. Fallion (Address) Johns Hopkins Hosp

15 Filed AUG 13 1930 C. WILLIAMSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 11, 1930, that I last saw her alive on Aug 10, 1930 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis (duration) yrs. mos 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Thos E. Shannon, M. D.

8/11, 1930 (Address) 700 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Cem. Date of Burial: Aug 13 1930

20 UNDERTAKER: Easton Lee Funeral Co. ADDRESS

—2-29-28—L. F. S.—500 Bks.

Hallie E. De Lashmutt

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59710

CERTIFICATE OF DEATH

49

E 59710

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

24-33

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 1331 Webster ST. WARD)

2—FULL NAME Hallie E. De Lashmutt.

(a) RESIDENCE NO. 1331 Webster ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
rale.	White.	arried.

married, widowed, or divorced
HUSBAND of
(or) WIFE of George W. De Lashmutt.

ATE OF BIRTH (month, day, and year) April 13, 1884

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45.	3.	27.	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Frederick, Md.
(State or country)

0 NAME OF FATHER Charles Bumgardner.

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

2 MAIDEN NAME OF MOTHER Lucretia King.

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

Informant George W. De Lashmutt.

(Address) 1331 Webster St.

Filed ....., 19 .... A. ..... Registrar

T 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10th 30.

17 I HEREBY CERTIFY, That I attended deceased from June, 19 27. to Aug. 10th, 19 30

that I last saw h alive on Aug 9th, 19 30

and that death occurred, on the date stated above, at 7. A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Hip 3 yrs
Complicated by Pleurisy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Retention

(duration) yrs 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. F. Shaw, M. D.

8-11, 1930 (Address) 536 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem. DATE OF BURIAL Aug 13, 1930

20 UNDERTAKER C. Edward Evans ADDRESS 38 E. Fayette

ec.—1-12-23—M&T—500 Blks.

E 59711 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Memorial Hosp REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1066 Calon ave ST. 11-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Minnie Rest

(a) RESIDENCE NO. 616 Park ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Rest

DATE OF BIRTH (month, day, and year): Nov. 27/1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
73 yrs.		4	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: John Karl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Sinai Memorial Hosp. 1066 Calon Avenue

15 Filed 1 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1930

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1929 to August 10, 1930

that I last saw her alive on August 10, 1930

and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hypertension Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (2) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Hiram S. Anderson, M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 8/12 1930

20 UNDERTAKER: H. S. Brauning Son

ADDRESS 1136 Poplar Grove St

c.—1-30—M. & T.—250 Bks.

Dr Straus 1145 E 90th ave

59712 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 59712

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 756 McKewin Ave ST. 11-47 WARD)

2-FULL NAME Mary A Schaumburg

(a) RESIDENCE NO. 756 McKewin Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Henry Schaumburg

DATE OF BIRTH (month, day, and year) Sept 21, 1842

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	10	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Frederick Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Henry Schaumburg

(Address) 756 McKewin Ave

Filed Aug 11 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Aug 10, 1930, that I last saw h... alive on Aug 10 1930, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis with hypertension

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Weis M. D.

Aug 11, 1930 (Address) 4508 Fred Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 8/13 1930

20 UNDERTAKER J. M. Cook

ADDRESS 121 S Paca St

c.—1-30—M. & T.—250 Bks

E 59713 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59713

32

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Mercy Hospital ST. 27-46 (WARD)

2-FULL NAME Miss Rose Wilson

(a) RESIDENCE NO. 506 Orkney Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced (or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 21, 1912

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18 yrs.	6	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) West Virginia

10 NAME OF FATHER Deceased.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER orphan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Mrs Funk 506 Orkney Road (Address)

Filed ....., 19 ..... Registrar

C. HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-5-30, 19..., to 8-10-30, 19...,

that I last saw her alive on 8-10-30, 19...,

and that death occurred, on the date stated above, at 8 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculan Meningitis

(duration) ...yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ...yrs. ...mos. 1. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Laboratory

(Signed) Bessie gardner ...., M. D.

, 19 (Address) Mercy Hospital Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral

UNDERTAKER Wilson & Son

DATE OF BURIAL 8 13 1930

ADDRESS 1217 E Paul St

1930 ..... 19 ..... Registrar

C.—1-30—M. & T.—250 Bks.

E 59714 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59714

CERTIFICATE OF DEATH. X 74-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt. Hope Retreat ST. 98-63 (WARD)

2-FULL NAME Jos. A. Frighan

(a) RESIDENCE NO. Mt Hope Retreat ST., 28 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Frighan

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	0	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Phila Pa

10 NAME OF FATHER Patrick Frighan

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan Boyle

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland

Informant Jennie T. Hughson

(Address) Philadelphia Pa

Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 31st, 1930, to Aug. 11, 1930, that I last saw h alive on Aug. 11, 1930, and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

(duration) yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

DATE OF BURIAL 8/12 1930

20 UNDERTAKER Fallhom Cook

ADDRESS 1207 St Paul St

c—1-30—M. & T.—250 Blks.

138710
E 59715

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59715

CERTIFICATE OF DEATH. X 1930

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7-9 ST., WARD)

2-FULL NAME Harriet Anthony

(a) RESIDENCE NO. Sparrows Point Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

If married, widowed, or divorced (HUSBAND) of (or) WIFE of

DATE OF BIRTH (month, day, and year) Oct-16-1848

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	82			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER Michael Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

Informant JOHNS HOPKINS HOSPITAL (Address) Friends

Filed 1930, 19 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10-1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to Aug 10, 1930, that I last saw h[illegible] alive on Aug 10 1930, and that death occurred, on the date stated above, at 5-25 a. m.

The CAUSE OF DEATH* was as follows:

Heart Exhaustion

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Old Fracture Femur / Humerus (duration) yrs. mos. 37 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Johns Hopkins Hosp M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dall Lawn Cemetery

DATE OF BURIAL Aug 12 1930

20 UNDERTAKER Robt F Turner

ADDRESS 942 E Broadway

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59716

E 59716

129

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Home (1506 Webster) ST. 24-36 WARD)

TY OF BALTIMORE: (No.

2-FULL NAME Salvatore Cavallaro

(a) RESIDENCE No. 1506 Webster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Cavallaro

DATE OF BIRTH (month, day, and year) Aug 27, 1880

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer Owner

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER John Cavallaro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosaria Ferrara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Mrs. Frances Cavallaro

(Address) 1506 webster st

Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1930, to Aug. 9, 1930, that I last saw him alive on Aug 9, 1930, and that death occurred, on the date stated above, at 10.40 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 5 mos da.

CONTRIBUTORY (Secondary) Nephritis + Uremia

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical + laboratory

(Signed) J. B. Savarese, M. D.

, 19 (Address) 436 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Aug 13 1930

20 UNDERTAKER Frank V. Pistone

ADDRESS 2018 E. Baltimore st

c.—1-30—M. & T.—250 Bks.

E 59717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 59717

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

(a) OF BALTIMORE: (No. University Hospital ST. 22-30 WARD)

2-FULL NAME Elizabeth Jordan

(a) RESIDENCE NO. 713 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Adam Jordan

DATE OF BIRTH (month, day, and year) Sept 15 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Hungary

10 NAME OF FATHER John Till

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

Informant Gertrude Koma

(Address) 713 W. Pratt St

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930, to Aug 10, 1930,

that I last saw her alive on Aug 10, 1930,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

with senile gangrene

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Senile gangrene - 5 wks.

Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Wylie M. Law, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Aug 12th, 1930

UNDERTAKER C. U. Wagaman ADDRESS 1850 N. Gay St

c.—1-30—M. & T.—250 Blks

E 59718 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59718

CERTIFICATE OF DEATH. 194

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. ST. 12-14 WARD)

2-FULL NAME Mr. Harry Ould Brawner

(a) RESIDENCE NO. Ruxton M.d. ST., WARD Ruxton, Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? 64 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

If married, widowed, or divorced
HUSBAND of (or) WIFE of Virginia Brawner

ATE OF BIRTH (month, day, and year) August 1867

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
3	62	~~11~~	~~11~~	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) ~~do~~

(c) Name of employer

IRTHPLACE (city or town) Charles Co. Md.
(State or country)

10 NAME OF FATHER John C Brawner

11 BIRTHPLACE OF FATHER (city or town) Washington DC
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Shugerman

13 BIRTHPLACE OF MOTHER (city or town) Washington DC
(State or country)

Informant (Son) Mr. Charles Brawner
(Address) Ruxton, Md.

Filed ..... 19 C. HAMPSON JONES, M. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 11, 1930,

that I last saw h~~im~~ alive on July 11, 1930

and that death occurred, on the date stated above, at 9 ~~20~~ m. Daylight saving

The CAUSE OF DEATH* was as follows:

Heart failure Pneumonia

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Cerebral arterio-sclerosis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Ruxton, Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical course.

(Signed) Jesse [illegible] M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug 13 1930
20 UNDERTAKER Stewart Memorial	ADDRESS Balto

c.—1-30—M. & T.—250 Bks.

E 59719 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59719

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 S Bond ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Zuchowska

(a) RESIDENCE NO. 728 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced: HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 1882

AGE: Years 48; Months; Days; If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Frank Kaminski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Joseph Zuchowski

(Address) 728 S. Bond St.

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10-1930

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Aug 10, 1930.

that I last saw h[illegible] alive on Aug 9, 1930

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 4 mos ds

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed William G Daniels M. D.

19 (Address) 801 N Lehmwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem DATE OF BURIAL: Aug 12 1930

20 UNDERTAKER: John M Weber ADDRESS: 1 Chester

C. THOMPSON JONES, M

c—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59720 E 59720

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Baltimore City Hospt. REGISTERED NO.

TY OF BALTIMORE: (No.) Balto Md (ST.) 26-29 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Zenecke

(a) RESIDENCE No. 6 N. Clinton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widow

If ~~married~~, widowed, ~~or divorced~~
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) 1855

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

IRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records Balto City Hospt.
(Address)

Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-10-30

17 I HEREBY CERTIFY, That I attended deceased from 7-22-~~30~~ 1930, to 8-10-1930

that I last saw her alive on 8-9-, 1930

and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Alex Fedorwitz M. D.

8/10 1930 (Address) Baltimore City Hospts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL Aug 12 1930

20 UNDERTAKER John W. Weber & Wm. Chester ADDRESS

c.—1-30—M. & T.—250 Bks

E 59721

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59721

43

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

TY OF BALTIMORE: (NO. ST 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teofilia Sumowska

(a) RESIDENCE NO. 17 S. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Paul

ATE OF BIRTH (month, day, and year) Unknown 1875

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0?

(c) Name of employer

IRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Frank Perszanawki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Herstrusbd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant (Address) Records of Balto. City Hospitals

Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-9-30

17 I HEREBY CERTIFY, That I attended deceased from 8-1-30, 19 to 8-9-30, 19

that I last saw her alive on 8-9-30, 19

and that death occurred, on the date stated above, at 11:00 A. m.

The CAUSE OF DEATH* was as follows:

Caycinoma of upper Jaw.

(duration) UNknown yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett. M. D.

8-9-30 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Aug 13 1930
20 UNDERTAKER	ADDRESS
John M. Weber	104 S. Chester St

c 1-30 M. & T.—250 Bks.

E 59722

HEALTH DEPARTMENT—CITY OF BALTIMORE

194 E. 59722

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) 3040 E. Monument ST., 9-11 WARD)

2-FULL NAME Maude F. Turner

(a) RESIDENCE NO. 3040 E. Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX F

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (~~write the word~~) married

If married, widowed, or divorced HUSBAND of (or) WIFE of Harry D. Turner

DATE OF BIRTH (month, day, and year) July 4 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Balto. City

10 NAME OF FATHER John C. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lusbrough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Harry D. Turner
(Address) 3040 E. Monument

Filed ..... 19 ..... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 10, 1930, that I last saw her alive on Aug 9, 1930, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:
Gastritis acute &
Heart Prostration

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Hearn M. D.

8/10 1930 (Address) 3901 Harrison Ave.

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Aug 12 1930
20 UNDERTAKER John C. Miller 2735	ADDRESS E. Oliver

C.—1-30—M. & T.—250 Hks

E 59723

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59723

CERTIFICATE OF DEATH.

REGISTERED NO. X 45

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) ST. 96-37 (WARD)

2-FULL NAME Emanuel Mitchell

(a) RESIDENCE NO. 715 E Lt Sparrow Pt. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1848

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) 011

(c) Name of employer

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant (Address) Records of Balto. City Hospitals

Filed 1 1 1930 C. HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-9-30

17 I HEREBY CERTIFY, That I attended deceased from 9-30-19 , 19 , to 8-9-30 , 19 , that I last saw him alive on 8-9-30 , 19 , and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of duodenum

(duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 12 yrs. mos. da.

18 Where was disease contracted if not at place of death? 1. Hospital 2. Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes. Autopsy

What test confirmed diagnosis?

(Signed) Paul Podgel. M. D.

8 9. 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul's Lem Cem DATE OF BURIAL 12 1930

20 UNDERTAKER John C. Miller ADDRESS 2135 E Monument

30—M. & T.—100 B—50L

59724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88-703 E 59724

REGISTERED NO. .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp ST. 25-72 WARD)

2-FULL NAME Robert Mackey

(a) RESIDENCE No. Roselyn Arlington ST., Va WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Victoria

10 NAME OF FATHER Chandler Mackey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Don't

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Randall Mackey
(Address) Roslyn Va

15 Filed 8 12 1930 Registrar C. J. CARROLL JONES, JR.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto in which he was riding collided with drum on road at excavation

(a) — (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wash Rd at Beltsville Md

Did an operation precede death? yes Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Surgical

(Signed) L. Frame Coroner, M. D.

8 12 1930 (Address) 2939 N. Eddy St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clarendon Va — DATE OF BURIAL 8/12 1930

20 UNDERTAKER Geo. W. Ives ADDRESS North Ave & Lamond Balto Md.
Geo. W. Dickneit & Son.

c.—1-30—M. & T.—250 Bks.

Dr Ogleheart 1403 Park Ave

E 59725 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59725

CERTIFICATE OF DEATH.

1941

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1619 Linden Ave St. 14-20 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett A. Lettig

(a) RESIDENCE NO. 1619 Linden Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced: (HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year): Dec 31, 1833

AGE: Years 96 | Months 4 | Days 8 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Luther Lettig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. Md

12 MAIDEN NAME OF MOTHER: Louisa Gittings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Md

Informant: Oscar Degull

(Address) 3514 Hartford Rd

Filed 8/12, 1930 Registrar

21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/6, 1930, to 8/10, 1930, that I last saw her alive on 8/10, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Fatal Prostration

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm Ogleheart, M. D.

8/11, 1930 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druimmount

DATE OF BURIAL: 8/12, 1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 E Pratt St

c. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

726 — 129 ✓ — REGISTERED NO. E 59726

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3313 Eggleston Ave. ST.) 15-63 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Spies

(a) RESIDENCE NO. 3313 Eggleston Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 3 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of George E. Spies Jr.

DATE OF BIRTH (month, day, and year) Apr 20. 1882

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	3	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: Archibald Rohr Co.

BIRTHPLACE (city or town) (State or country): Baltimore Maryland

10 NAME OF FATHER: John Figuitt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Maryland

12 MAIDEN NAME OF MOTHER: Clara Woelfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: E. Wilson Spies

(Address): 3313 Eggleston Ave.

Filed AUG 12 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1930, to Aug. 9, 1930, that I last saw h[illegible] alive on Aug. 9, 1930 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Coronary Occlusion

CONTRIBUTORY (Secondary) Chronic Pancreatitis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) [illegible], M. D.

8/14, 1930 (Address) 1663 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cem. DATE OF BURIAL: Aug 12 1930

20 UNDERTAKER: Chas. B. Cook ADDRESS: 1003 W. Pratt St.

Thelma Durr

E 59727 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 59727

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (a) RESIDENCE NO. West Baltimore Gen Hosp. 7-29 WARD)

2-FULL NAME Thelma Durr

(a) RESIDENCE NO. 1236 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of George Durr

7 DATE OF BIRTH (month, day, and year) Feb. 22, 1903

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	27	5	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

BIRTHPLACE (city or town) (State or country) Norfolk Virginia

10 NAME OF FATHER J. E. Blanchard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER S. E. Simes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Alma Blanchard

(Address) 1934 Wilkens Ave.

15 Filed , 19 HAMILTON JONES, M. D. Registrar

2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/11/30 19

17 I HEREBY CERTIFY, That I attended deceased from 6/21/30, 19 , to 8/11/30, 19 ,

that I last saw her alive on 8/11/30, 19

and that death occurred, on the date stated above, at 12:45 Am

The CAUSE OF DEATH* was as follows:

renal calculus and chronic nephritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/5/30

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. Ashman, M. D.

8/11 19 30 Address) W. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Aug. 13 1930

20 UNDERTAKER Wm. H. Cook

ADDRESS 1003 West Baltimore St

c.—1-30—M. & T.—250 Bks.

59728

HEALTH DEPARTMENT—CITY OF BALTIMORE CE 59728

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) Univ Hosp ST. WARD)

2-FULL NAME Jennie Bell.

(a) RESIDENCE NO. Hamiltonsville, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed.

If married, widowed, or divorced (HUSBAND) of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 23 1866

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63.	10	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) New York

10 NAME OF FATHER John Doty

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs Dr. Wetzoff

(Address) Cassanton Md

Filed [illegible] 19[illegible] [illegible] JAMES BONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11-30

17. I HEREBY CERTIFY, That I attended deceased from 8-2, 19 30, to 8-11, 19 30,

that I last saw h[illegible] alive on 8-11, 19 30,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cecum.

Arteriosclerosis general.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency, (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 8-3-30.

Was there an autopsy? no.

What test confirmed diagnosis? Clin & Operation

(Signed) Henry D. Allen, M. D.

, 19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Uniontown Md

DATE OF BURIAL Aug 14 1930

20 UNDERTAKER H Bankard & Son

ADDRESS Westminster

c.—1-30—M. & T.—250 Bks

59729 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59729

CERTIFICATE OF DEATH. 1441

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2203 Lynnbrook (St.) Ave (WARD)

2-FULL NAME Anetta Mary Ford

(a) RESIDENCE NO. 2203 Lynnbrook Ave (St.) (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Ford.

6 DATE OF BIRTH (month, day, and year) Nov 14, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Fred. Kikel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ullman

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

Informant Mr. Charles L. Ford

(Address) 2203 Lynnbrook Ave.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Aug 10, 1930, that I last saw her alive on Aug 10, 1930, and that death occurred, on the date stated above, at 2.55 P m.

The CAUSE OF DEATH* was as follows:

Postpartum Hemorrhage
Pulmonary Embolism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease 12, 15 mos

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Cline, M. D.

8/11/30 (Address) 2757 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Aug. 13, 1930

UNDERTAKER W. J. Fleckner Sons ADDRESS Northern

...-2-29-28—L. F. S.—500 Bks.

59730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Rembold

X 45 ✓

REGISTERED NO. E 59730

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Maryland General Hospital ST. (or WARD)

2—FULL NAME Mrs. Rebecca Rembold

(a) RESIDENCE NO. Edgewood, Md. ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 11 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	76	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Md.

10 NAME OF FATHER Casper Rembold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Eisching

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

Informant William Edgewood Md

(Address)

Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/12/1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5 1930, 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Intestinal Obstruction (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Robert F. Chenoweth, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Ursulas, Brooklyn, Md

DATE OF BURIAL Aug 14 1930

20 UNDERTAKER Edward R. McGowan

ADDRESS Abingdon

21930 Phillip Jones M. D.

c.—1-30—M. & T.—250 Bks.

E 59731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

E 59731

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 1823 E 29th ST., 9-46 WARD)

2-FULL NAME Mary M. Hill

(a) RESIDENCE NO. 1823 E 29th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

f married, widowed, or divorced HUSBAND of (or) WIFE of James C. Hill

ATE OF BIRTH (month, day, and year) June 18th 1854

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	1	17	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (City or town) (State or country) Baltimore Md

10 NAME OF FATHER Frederick Prutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Charles S. Hill

(Address) 2836 Alameda Blvd

Filed 2 1930, 19 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1930

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to Aug 10, 1930,

that I last saw her alive on Aug 10, 1930

and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilitation

(duration) yrs. mos 1. ds.

CONTRIBUTORY (Secondary) Aortic + mitral

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ernest L. Zimmerman M. D.

8/11, 19 30 (Address) 857 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews

DATE OF BURIAL Aug 13 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

C—1-30—M. & T.—250 Bks.

9732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Register Hyte

123 E 59732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4401 Colborn Rd ST. 28-61 WARD)

2-FULL NAME Emma Roberta Santos

(a) RESIDENCE NO. 4401 Colborn Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Hamman Santos

DATE OF BIRTH (month, day, and year) Dec 18/1848

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	81	7	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Calvin Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Stigby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Edgar L. Santos

(Address) 6404 Pinehurst Rd.

Filed AUG 12 1930, 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930, to Aug 10, 1930, that I last saw h... alive on Aug 10, 1930, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Biliary (Hepatic) (Empyema) Obstruction

(duration) ? yrs. ? mos ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo McKeffer, M. D.

Aug 11 1930 (Address) 2454 Madison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Aug 13 1930

20 UNDERTAKER Philips Herwig

ADDRESS 2016 Eutaw Pl

rec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59733

CERTIFICATE OF DEATH.

E 59733

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 405 N. Carrollton Ave (ST.) 18-16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Mae Ridgeway

(a) RESIDENCE NO. 405 N. Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 8, 1928

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		10		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Albert E. Ridgway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mrs. Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant (Address) Albert E. Ridgeway 405 N. Carrollton Ave

Filed Aug 12, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-10-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug-9-1930 to Aug-10-1930

that I last saw h alive on Aug-10-1930 at 1135 A m

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Enteritis

Duration yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Ethanatyte 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J B Stuples M. D.

(Address) 1413 Druid Hill Ave

Aug 10 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug 12, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 E Lanvale St.

59734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 59734

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Fultrop ST. 16-68 WARD)

2-FULL NAME C. Leonard Hachtel

(a) RESIDENCE NO. Braeside Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs — mos — 11 ds. How long in U. S. if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Hazel H. Hachtel

DATE OF BIRTH (month, day, and year) Nov. 29, 1899

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	30	8	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Rail Way Co

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER L. F. Hachtel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Blanche Craggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Hazel H. Hachtel

(Address) Braeside Rd

Filed AUG 12 1930 KK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1930

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Aug 11, 1930,

that I last saw h Alive on Aug 11, 1930

and that death occurred, on the date stated above, at 8 05 P m

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Ashman, M. D.

, 19 (Address) W. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL AUG 14 1930

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE

c—1-30—M. & T.—250 Bks.

59735

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 59735

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number)

TY OF BALTIMORE: (No. Mt Hope Retreat ST. 25-63 WARD)

2-FULL NAME Dorothy Mourse

(a) RESIDENCE NO. Elizabeth N.J. ST., ... WARD Elizabeth N.J.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? 26 yrs. 3 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

DATE OF BIRTH (month, day, and year) May 11. 1904

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	3	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) (State or country) Elizabeth New Jersey

10 NAME OF FATHER John V. Mourse

11 BIRTHPLACE OF FATHER (city or town) Elizabeth (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Isabel Beamon

13 BIRTHPLACE OF MOTHER (city or town) Elizabeth (State or country) New Jersey

Informant Mt Hope Friends (Address) Mt Hope Retreat.

Filed AUG 12 1930 RK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11. 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Aug 11, 1930,

that I last saw her alive on Aug 11, 1930,

and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Fibroid Phthisis

Contributory Dementia Praecox

Antecedent (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Antecedent

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter P. Bell M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elizabeth N. J.	Aug 14 1930
20 UNDERTAKER Stewart & Mounts	ADDRESS Falls

c.—1-30—M. & T.—250 Bks.

239038
2 Med
E 59736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 59736

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

TY OF BALTIMORE: (No. ST., 314 WARD)

2-FULL NAME Robert Anderson

(a) RESIDENCE NO. 326 So. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64	44			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed 2 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9- 1930

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to Aug 9, 1930,

that I last saw him alive on Aug 9, 1930,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

cerebral accident (haemorrhage)

(duration) yrs. 1 mos 21 ds.

CONTRIBUTORY (Secondary) anemia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? found unconscious on street

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? P.M. examination

(Signed) Emil F. Cekada M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cretury Conn	Aug 12 1930
20 UNDERTAKER	ADDRESS
Kendel D Lippel	300 N Eden

30—M. & T.—100 B—50L

E 59737

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 59737

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Madison Ave WARD

2-FULL NAME Margaret J Thompson

(a) RESIDENCE NO 1801 Madison Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of no

DATE OF BIRTH (month, day, and year) June 28 1914

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	2	13	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Lancaster Pa

10 NAME OF FATHER Isiah Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lucy Whelo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Daisy Thompson

(Address) 1801 Madison Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 10th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Phthisis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Holland, M. D. Coroner

(Address) 4/10

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery DATE OF BURIAL 4/12/1930

20 UNDERTAKER Mrs. George H. Holland ADDRESS 1631 Div

21930

Patrick Jones M.D.

c.—1-30—M. & T.—250 Bks

E 59738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 59738

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

TY OF BALTIMORE: (NO. ST., 5-C WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Morris

(a) RESIDENCE NO. 624 N. Central ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) May 27, 1888

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Lynchburg, Va.

10 NAME OF FATHER Chester Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Hospital Records

(Address)

Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to Aug. 9, 1930, that I last saw him alive on Aug. 9, 1930, and that death occurred, on the date stated above, at 8.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jenner, M. D.

8-9, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL AUG 12 1930 19

20 UNDERTAKER

ADDRESS

Commissioner Health

c—1-30—M. & T.—250 Bks.

E 59739 HEALTH DEPARTMENT—CITY OF BALTIMORE 75 E 59739

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospital

TY OF BALTIMORE: (No. ST. 11-24 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Robinson

(a) RESIDENCE No. 926 N Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	colored	widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67		—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launders

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

IRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Fred Scott

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Gibson

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Va.

Informant Records of Baltimore City Hosp.
(Address)

Filed AUG 12 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-8-30

17 I HEREBY CERTIFY, That I attended deceased from 12-4, 1929, to 8-8, 1930, that I last saw h[illegible] alive on 8-8-30, 1930, and that death occurred, on the date stated above, at 6 3/4 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cecum

(duration) Unknown yrs. Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Fred M. Buckmaly, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL AUG 12 1930 19

20 UNDERTAKER

ADDRESS

[illegible] Commissioner Health

30—M. & T.—100 B—50L

E 59740

59740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. WARD 7-24-98

2-FULL NAME Jas. Jackson

(a) RESIDENCE NO 1928 E. Pine ST., ... WARD 7

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | 4 COLOR OR RACE Col'd | 5 Single, Married, Widowed, or Divorced (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Single

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed AUG 2 1930 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon, and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Homicide
Hemorrhage due to
Stab wound of heart
(duration) yrs. Instantaneous

CONTRIBUTORY (Secondary) (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) H. C. Finch, M. D. Coroner

Aug 2 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

AUG 1 2 1930

PUBLIC CEMETERY

Commissioner Health.

AUG 2 1930

HENRY JONES, M. D.

THE MORGUE

30—M. & T.—100 B—50L

E 59741

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59741

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 W Hoffman St. WARD) 17-24

2-FULL NAME Elizabeth Stanley

(a) RESIDENCE NO 535 W Hoffman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widowed

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Va

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Carrie Haughton

(Address) 535 W Hoffman

15 Filed AUG 12 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] Coroner, M. D.

19 (Address) [illegible] Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL AUG 12 1930

20 UNDERTAKER

ADDRESS

Commissioner Health.

THE MORGUE

Rec. 8-16-29 L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 59742

E 59742

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S.Marine Hospital, ST. 18-16 WARD) Baltimore, Maryland

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellert A. Nelson

(a) RESIDENCE NO. 815 West Saratoga St. ST., WARD
(Usual place of abode) Baltimore, Maryland
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

DATE OF BIRTH (month, day, and year) October 29,1885

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	9	9 10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer 0-0

(b) General nature of industry, business, or establishment in which employed (or employer) SS Atlantic

(c) Name of employer SS Atlantic of N.Y.City

BIRTHPLACE (city or town) Lansing
(State or country) Iowa

10 NAME OF FATHER Larson Nelson

11 BIRTHPLACE OF FATHER (city or town) Ia
(State or country) Iowa

12 MAIDEN NAME OF MOTHER Julia Jenkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Iowa

Informant Hospital Records
(Address) U.S.Marine Hospital,Balto.,Md.

Filed AUG 12 1930, 19 H. KEY JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15th, 1930, to August 9th 1930, that I last saw him alive on August 9th, 1930 and that death occurred, on the date stated above, at 2:10 P m. Stand.Tim

The CAUSE OF DEATH* was as follows:

Epithelioma of pharynx,

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis, pulmonary, chronic active. (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of July 27,1930

Was there an autopsy? no

What test confirmed diagnosis? biopsy

(Signed) Gordon A. Abbott, M. D.

19 (Address) U.S.Marine Hospital, Baltimore, Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's, Hampden	Aug. 12 1930
20 UNDERTAKER	ADDRESS
E. Leroy Stiffler, & no.	125 E. North ave.

S-16-29—L. F. S.—100 Bks.

59743 HEALTH DEPARTMENT—CITY OF BALTIMORE 59743

CERTIFICATE OF DEATH X 101-09

REGISTERED NO.

1—PLACE OF DEATH U.S. Marine Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Baltimore, Md. ST. 12-51 WARD)

2—FULL NAME Leoncio Patnogat

(a) RESIDENCE NO. 526 Barcelona St., St. Nicolas, Manila, P.I. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. 1 mos. 23 ds. How long in U. S., if foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Regina Acular

ATE OF BIRTH (month, day, and year) Nov. 12, 1895

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	8	28	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Eastern Glade

BIRTHPLACE (city or town) (State or country) Phillipine Islands

10 NAME OF FATHER Brullo Patnogat

11 BIRTHPLACE OF FATHER (city or town) (State or country) P.I.

12 MAIDEN NAME OF MOTHER Bonshana Andradi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) P.I.

Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

Filed AUG 12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 19 30, to August 10, 19 30, that I last saw him alive on August 10, 19 30 and that death occurred, on the date stated above, at 8:35 A. m. EST

The CAUSE OF DEATH* was as follows:

Nephritis, parenchymatous, acute

Laryngitis, phlegmonous, chronic

(duration) 1 yrs. 23 unknown {Neph Lar.}

CONTRIBUTORY (Secondary) Pneumonia, broncho, left lung

Pneumonia, lobar, right lung, lower lobe (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Gordon A. Abbott, M. D.

8/11, 19 30 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City, N.Y.	Aug. 12, 1930
20 UNDERTAKER E. Leroy Stiffler, Inc.	ADDRESS 125 E. North ave.

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 ✓ E 59744

CERTIFICATE OF DEATH

E 59744

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4004 E Monument St. WARD 34)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Funke

(a) RESIDENCE NO 4004 E Monument St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Funk

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Fredrick Heindel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Edna Funk

(Address) 4004 E Monument St.

15 Filed ..... 192 C. HAMPSON JONES, M. D. Registrar

27 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 6 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 2 mos ago

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. C. Hades, M. D. Coroner

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL Aug. 13 1930

20 UNDERTAKER Mas E. Miller & Son — ADDRESS 2300 Madison Ave

C.—1-30—M. & T.—250 Bks

E 59745

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59745

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.

2-FULL NAME John Welsh

(a) RESIDENCE NO. 702 S. Bethel st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND) of
or) WIFE of

DATE OF BIRTH (month, day, and year) July 30, 1886

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	9	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unkno2n

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Matthew Welsh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Jennie Seiler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Hospital Records
(Address)

Filed AUG 2 1930, 19 C. HUBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to Aug. 11, 1930,

that I last saw him alive on Aug. 11, 1930,

and that death occurred, on the date stated above, at 6.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Seiler, M. D.

8-11 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 8/13 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt

c.—1-30—M. & T.—250 Bks

59746 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59746

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Mercy Hospital REGISTERED NO. 15-62

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME John H. Kenney

(a) RESIDENCE NO. 3910 Dorchester Ref ST., 3710 Dorchester Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	~~Married~~ Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Jennie B. Kenney

DATE OF BIRTH (month, day, and year) July 16, 1867

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63 6-2	-	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance —

(b) General nature of industry, business, or establishment in which employed (or employer) 011

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N.J. Readington

10 NAME OF FATHER Peter Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kenney's Mills N.J.

12 MAIDEN NAME OF MOTHER Matilda Wycoff Wisthoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.J.

14 Informant Hospital Records

(Address)

15 Filed 12 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/12/30

17 I HEREBY CERTIFY, That I attended deceased from 5-27, 1930, to 8-12, 1930, that I last saw h[e] alive on 8-12, 1930, and that death occurred, on the date stated above, at 7^5 A' m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy Prostate

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6-23-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Obs.

(Signed) J Leyko M. D.

8/12 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Somerville, N. J.

DATE OF BURIAL Aug. 15 1930

20 UNDERTAKER Joseph D Cook

ADDRESS 1003 West Baltimore St

130—M. & T.—250 Bks.

E 59747 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 59747

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1550 Bayle St. 24-34 (WARD)

2-FULL NAME Fletcher Schreckers

(a) RESIDENCE NO. 1550 Bayle St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Waters

DATE OF BIRTH (month, day, and year) March 8 1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Benjamin Schreckers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Schreckers Son (Address) 1550 Bayle St

15 Filed Aug 21 1930 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10-1930

17 I HEREBY CERTIFY, That I attended deceased from June 10 1930 to Aug 10 1930.

that I last saw him alive on Aug 10 1930.

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinically

(Signed) H. K. Campbell M. D.

Aug 21 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Aug 13 1930

20 UNDERTAKER Chas. L. Stevens ADDRESS 1601 E Fort Ave

c.—1-30—M. & T.—250 Blks

E 59748 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59748

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (NO. 15-18 ST., WARD)

2-FULL NAME Clara Velte

(a) RESIDENCE NO. 1826 Whitemore Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

If married, widowed, or divorced (~~HUSBAND~~) of or) WIFE of Henry Velte

DATE OF BIRTH (month, day, and year) March 16, 1868

AGE: Years 62 Months 4 Days 24 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER Martin Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Clara ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

Informant: Records

(Address): BALTIMORE CITY HOSPITALS

Filed 8-21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Aug 10, 1930, that I last saw her alive on Aug 10, 1930, and that death occurred, on the date stated above, at 5:40 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of liver (NOT alcoholic) (duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

8-10-1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catonsville

DATE OF BURIAL: 8/13 1930

20 UNDERTAKER: J. F. Staley & Sons

ADDRESS: 1318 Eutaw

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59749 ✓ 90 E. 59749

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 705 Edgewood ST. 16-67 WARD)

2—FULL NAME Irene Pennington

(a) RESIDENCE NO. 705 Edgewood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
F.	W.	Widow

If married, widowed, or divorced WIFE of (or) HUSBAND of Charles Pennington

6 DATE OF BIRTH (month, day, and year) July 26-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	X	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER James Pennington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

Informant D D Plumb

(Address) 705 Edgewood St

Filed Aug 12 1930 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 1922, to Aug 1930,

that I last saw h alive on Aug 8 1930

and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage, arteriosclerosis and chronic nephritis

Contributory Cystitis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Pleasant Cemt Gardens Md	Aug 13 1930
20 UNDERTAKER Lawrence Co Md	ADDRESS
Pritchard & Co	1723 N Fayette Ave

c.—1-30—M. & T.—250 Bks.

E 59750 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59750

CERTIFICATE OF DEATH. X 135

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Nursing Home ST., 4-30 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gottfried Lang.

(a) RESIDENCE NO. Rolling Rd - Woodlawn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Susan Margaret Lang

DATE OF BIRTH (month, day, and year) June 22. 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	1	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conservative

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ober Franken Germany

10 NAME OF FATHER John Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Susie M. Lang (Wife)

(Address) Woodlawn, Md.

Filed 8-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10/30.

17 I HEREBY CERTIFY, That I attended deceased from 8-8, 19 30, to 8-10, 19 30,

that I last saw h[illegible]live on 8-10, 19 30

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of prostate benign

(duration) autopsy. yrs. mos. da.

CONTRIBUTORY (Secondary) Uremia. (duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? [illegible].

Did an operation precede death? yes Date of 8-9-30

Was there an autopsy? no.

What test confirmed diagnosis? Clin. & Operation

(Signed) Henry D. [illegible] M. D.

8/13, 19 30 (Address) Nursing Home.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery.

DATE OF BURIAL Aug. 13. 1930

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS Baltimore St & Broadway

c.—1-30—M. & T.—250 Blks.

Annie Houck

HEALTH DEPARTMENT—CITY OF BALTIMORE

59751 E 59751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Annie Houck ST. 1 WARD)

2-FULL NAME 1110 Greenmount Ave

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) 11-15-1866

GE	Years	Months	Days	If LESS than 1 day hrs. or min.
	63	8	27	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Lawrence Hough

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Anna Hough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

Informant Lisie Louis

(Address) [illegible]

FILED 3 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-30

17 I HEREBY CERTIFY, That I attended deceased from 8-4-30, 19..., to 8-6-30, 19...,
that I last saw h[illegible] alive on 8-6-30, 19...,
and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Agranulocytic Angina

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic Exam

(Signed) W B Hurst, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Govans

DATE OF BURIAL 8/13/30 19

20 UNDERTAKER George E Pentz Inc

ADDRESS 1730 Harford

c.—1-30—M. & T.—250 Bks

59752 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 59752

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ST. 17-24 WARD)

2-FULL NAME Clarence Majett

(a) RESIDENCE NO. 1104 Druid Hill ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1900

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29 30			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Georgia

10 NAME OF FATHER Benj. Majett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maggie Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Hospital Records

(Address)

FI[illegible] 1930 C. H[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8, 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1930, to Aug. 8, 1930,

that I last saw him alive on Aug. 8, 1930,

and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of.

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Harold Leuner, M. D.

8-9, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Aug 13 1930

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Presstman St

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59753

E 59753

128

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 4603 Asbury Ave ST. Sardenville WARD 26-41

2-FULL NAME Shirley Ann House

(a) RESIDENCE NO. 4603 Asbury Ave ST., Sardenville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Jan. 14 1923

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	6	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Jesse H. House Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret E. Horn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Mr. Jesse H. House Sr

(Address) 4603 Asbury Ave Sardenville

Filed 1-3 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1930

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to Aug 11, 1930,

that I last saw h[illegible] alive on Aug 11 1930

and that death occurred, on the date stated above, at 4 P.M. Standard m.

The CAUSE OF DEATH* was as follows:

Acute Diffuse Nephritis

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8/12, 1930 (Address) 936 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Aug. 13 1930

20 UNDERTAKER Henry Hoeck Sons Inc. — ADDRESS 1301 E Eager St

c.—1-30—M. & T.—250 Blks.

E 59754 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59754

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 8. S. East Ave ST. 1-W WARD)

2-FULL NAME Arthur T. Allen

(a) RESIDENCE NO. 8. S East Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of Mary M. allen

DATE OF BIRTH (month, day, and year) Apr 14-1857

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	76	3	29	

OCCUPATION OF DECEASED Clerk.

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Wm a allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Crutchfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Mary V. Allen
(Address) 8. S East Ave

Filed ..... 19 HAMILTON JONES, M. D.
Registrar

AUG 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12th 30

17 I HEREBY CERTIFY, That I attended deceased from Aug 12th 19 30, to Aug 12th 19 30,
that I last saw him alive on Aug 12, 19 30
and that death occurred, on the date stated above, at 6 40 A m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. H. Hamman M. D.

19 (Address) 1710 E 32nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Aug 14 30

20 UNDERTAKER John Elliott

ADDRESS 200 E Preston

ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59755

CERTIFICATE OF DEATH.

57 E 59755

REGISTERED NO.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) Sinai Hospital ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Trier

(a) RESIDENCE NO. 1237 N. Hare ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Joseph Trier

DATE OF BIRTH (month, day, and year) Dont Know

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER — Leitch.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs. Chas Mattaway

(Address) 1237 N Hare St

Filed AUG 13 1930 JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10/30

17

I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930, to Aug 10, 1930,

that I last saw her alive on Aug 10, 1930,

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chr. Coronary occlusion

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Milton B Kirsh, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Aug. 13 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Edmondson

ec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE D 59756

CERTIFICATE OF DEATH.

101-001

59756

1-PLACE OF DEATH Baltimore City Hospitals 2-4 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO.

2-FULL NAME Anton Plitt

(a) RESIDENCE NO. 2004 Bank St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Julia PLITT

DATE OF BIRTH (month, day, and year) March 15, 1877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER George Plitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Frances Sorbed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of
(Address) Balto. City Hospitals

Filed 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-10-30

17 I HEREBY CERTIFY, That I attended deceased from 6-23-30, 19, to 8-10-30, 19

that I last saw him alive on 8-10-30, 19

and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Empyema of Pleura

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic UNKNOWN.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

8-11 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL Aug. 13th 1930

20 UNDERTAKER Lilly & Zeiler Bros.

ADDRESS 403 S. Wolfe St

30—M. & T.—100 B—50L

E 59757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59757

REGISTERED NO. 75

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3009 Fait Av ST., 1-1 WARD)

2-FULL NAME Elizabeth Dorothy Locher

(a) RESIDENCE NO 3009 Fait ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel Locher

7 DATE OF BIRTH (month, day, and year) Nov 4 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Caspar Albert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Samuel Locher

(Address) 3009 Fait Ave

Filed AUG 3 1930, 192

H. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Sclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy Ex

(Signed) H C Eades, M. D.
Coroner

, 19 (Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Aug 6 1930
20 UNDERTAKER Lilly & Zeiler Inc	ADDRESS 1003 N Wolfe St

ec.—1-30—M. & T.—250 Bks.

E 59758 E 59758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 161-00

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 825 Mapleton Ave ST. [illegible] WARD 26)

2-FULL NAME Infant of Frank & Katherine Seibert

(a) RESIDENCE NO. 825 Mapleton Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced (a) HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 10th 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant (W)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Frank Seibert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Katherine Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Frank Seibert (Father)

(Address) 825 Mapleton Ave

Filed [illegible] 19 [illegible] Registrar

13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12th/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Aug 12, 1930,

that I last saw h[illegible] alive on " 16, 1930,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Acute

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Hearn M.D.

8/12, 1930 (Address) 3907 Fairview

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 15 1930
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Sys	401 S. Wood St

30—M & T—100 B—50L

E 59759

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59759

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) J. H. Hospital (ST.) 10-1 (WARD) 19

2-FULL NAME Ellis Thompson

(a) RESIDENCE NO 1421 Eager ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Thompson

7 DATE OF BIRTH (month, day, and year) 1907

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Union Sellers N. C.

10 NAME OF FATHER Roland Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Lillian Thompson

(Address) 1421 Eager St.

Filed OCT 13 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide Revolver Gunshot of Heart

CONTRIBUTORY (Secondary) Haemorrhage (duration) yrs. mos — ds.

(duration) yrs. mos. — da.

18 Where was disease contracted if not at place of death? 6 Eager & Guy St.

Did an operation precede death? No Date of 8-7-30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jos Clinton Blades, M. D. Coroner

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Asbury Cem

DATE OF BURIAL Aug 13 1930

20 UNDERTAKER Mrs J. J. Socks

ADDRESS 1802 Jefferson

ec.—1-30—M. & T.—250 Bks

E 59760 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59760

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Rappola St., 26-42 WARD) 24-00

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Kirkwood

(a) RESIDENCE NO. 4316 LaSalle ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Geo. H. Kirkwood

DATE OF BIRTH (month, day, and year) Sept 23 1872

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	10	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Henry Rehlberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ella M. Bates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

Informant Geo. H. Kirkwood
(Address) 4316 Lasalle ave

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

AUG 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1930.

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 27, to Aug 10, 19 30,

that I last saw h... alive on Aug 9, 19 30,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Arteriosclerosis

(duration) yrs. mos ..... da.

CONTRIBUTORY (Secondary) Diabetes

(duration) 1 yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. C. Hampson Jones, M. D.

Aug 13, 19 30 (Address) 1737 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL Aug 13 1930

20 UNDERTAKER George W. Zinkler — ADDRESS 1737 E. Eager St

c.—1-30—M. & T.—250 Bks

E 59761 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59761

CERTIFICATE OF DEATH.

REGISTERED NO. 47 5-62

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3104 Cold Spring Ave (ST.) (WARD)

2-FULL NAME Minnie Adelaide Kendall

(a) RESIDENCE NO. 3104 Cold Spring Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Victor E. Kendall

DATE OF BIRTH (month, day, and year) May 9 1874

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	3	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Havre de Grace Md

10 NAME OF FATHER Wm Ogman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Walter C. Kendall

(Address) 1765 Montpelier St.

C. HAMPSON JONES, M. D. Registrar

Filed 31930, 19 Reg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929 to Aug 10, 1930, that I last saw h[illegible] alive on Aug 10, 1930 and that death occurred, on the date stated above, at 11.15 a m EST.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of ✓

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E Wells Hemming M. D.

8/11/30 (Address) 7000 Hollins Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Orems Cem. Balto Co Md

DATE OF BURIAL Aug 13 1930

20 UNDERTAKER Wm J. Fleckner Sons

ADDRESS Norrisville Pa

-20—M. & T.—100 B—50L

E 59762

90

59762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 916 Argyle St. 17-23 WARD)

2-FULL NAME Henrietta Randall

(a) RESIDENCE NO. 916 Argyle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single

6 If married, widowed, or divorced: HUSBAND of (or) WIFE of No

7 DATE OF BIRTH (month, day, and year) 1896

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Baltimore Md

11 NAME OF FATHER Sommerfield Randall

12 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

13 MAIDEN NAME OF MOTHER Catherine Harris

14 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

15 Informant Emma Randall

(Address) 918 Argyle

Filed AUG 13 1930 19 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated ~~above~~ The CAUSE OF DEATH was as follows:

Mitral Insufficiency
Acute Dilatation
of Heart (duration) yrs. Sudden

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Regular

What test confirmed diagnosis? H. Leish, M. D.

(Signed) Coroner

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brown's Hill Cem. DATE OF BURIAL Aug 14 30

20 UNDERTAKER Saml Hensley ADDRESS W Balto

30—M & T—100 B—501.

James Curry

E 59763

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59763

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 1775 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Curry

(a) RESIDENCE NO 2556 Race ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C.	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) 1896

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Unknown

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Elizabeth Beasley

(Address) 2556 Race

15 Filed 3 1930 192 Mar HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac arrhythmia of Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hampson Jones Coroner, M. D.

8/12 1930 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 8-13 1930

ADDRESS 716 Oa ave.

20 UNDERTAKER Daniel Burton

7-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59764

CERTIFICATE OF DEATH.

91-002 E 59764

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME Henry Mueller

(a) RESIDENCE NO. Preston & Valley ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. [illegible]

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Henry Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Louise Otten

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Little Sisters of the Poor
(Address) Preston + Valley St

Filed 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930 to Aug 13, 1930

that I last saw h alive on Aug 12, 1930

and that death occurred, on the date stated above, at 6. a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senility
Unknown (duration) ....yrs. ....mos ....ds.

CONTRIBUTORY
(Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Benkendorf M. D.

8/13/30 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Aug 14 1930

20 UNDERTAKER Rita Muedefeld

ADDRESS 814 Fremont Ave

...C.—1-30—M. & T.—250 Bks.

Alisea

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59765 — 162 — E 59765

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital 9145

...TY OF BALTIMORE: (No. ~~Balto~~ Caroline ST. WARD)

2-FULL NAME Baby Boy Alisea

(a) RESIDENCE NO. 3409 Lake Montebello Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	New Born

If married, widowed, or divorced
HUSBAND of
or) WIFE of —

...ATE OF BIRTH (month, day, and year) aug. 11, 1930

...GE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		1	

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work c

(b) General nature of industry, business, or establishment in which employed (or employer) c

(c) Name of employer c

...IRTHPLACE (city or town) (State or country) Balto. md.

10 NAME OF FATHER Robert Lee Alisea

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto. md.

12 MAIDEN NAME OF MOTHER Vera Coath

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto md

Informant (Address) Robert L. Alisea 419 W. Balto. St.

Filed 8 13 1930 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-12-30

17 I HEREBY CERTIFY, That I attended deceased from 8-11-30, 19..., to 8-12, 19 30,

that I last saw h...alive on 8-12, 19 30,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) W. B. Handley M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Hartford Rd.

DATE OF BURIAL aug. 13 1930

UNDERTAKER Eerley & Co. Inc.

ADDRESS 1021 Lafayette

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59766 ✓ 129 E 59766

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 E. Monument St. 7-13 WARD)

2-FULL NAME John Purnell

(a) RESIDENCE NO. 1602 E. Monument ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Priscilla Purnell

6 DATE OF BIRTH (month, day, and year) — — 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
	78	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Labor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Snow Hill Md
(State or country)

PARENTS

10 NAME OF FATHER John Purnell

11 BIRTHPLACE OF FATHER (city or town) Snow Hill Md
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Emma Moody
(Address) 1602 E. Monument

15 Filed AUG 13 1930 C. HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1930, to Aug 11, 1930, that I last saw h— alive on Aug 11, 1930, and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Chronic Myocarditis
Chronic Sclerosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) W. L. Berry, M. D.

, 19 (Address) 1420 E. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Aug 14 1930
20 UNDERTAKER	ADDRESS
Chas H. Feeley	1421 Gilmor

cc—1-30—M. & T.—250 Bks.

E 59767 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59767

CERTIFICATE OF DEATH.

89

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 1 W. Franklin ST. 4-25 WARD)

2-FULL NAME Lyman E. Davis

(a) RESIDENCE NO. 1 W. Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ella Hood Davis

DATE OF BIRTH (month, day, and year) Dec 28 1854

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	7	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman 018

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) .....
(State or country) Ohio

10 NAME OF FATHER John F. Davis

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Martha Powers

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ohio

Informant Mrs. Ella Hood Davis
(Address) Rochester, N.Y.

FILED 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7 - , 1929, to Aug. 13 - , 1930, that I last saw h[illegible] alive on Aug. 12 - , 1930, and that death occurred, on the date stated above, at 12:20 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

8/13, 1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Adrian, Mich.	Aug 12 19 30
20 UNDERTAKER John A. Mitchell & Son	ADDRESS 1900 Eutaw

cc—1-30—M. & T.—250 Bks.

Mason K. Johnston ✓

E 59768

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59768

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1743 Hanover ST. 23-32 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mason K. Johnston.

(a) RESIDENCE NO. 1743 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Infant.

If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

DATE OF BIRTH (month, day, and year) July 24, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Maurice Johnston.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Bessie Mc. Donough.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Bessie Johnston, (Mother).

(Address) Va.

Filed 3 1930, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12-1930

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1930 to Aug 12, 1930, that I last saw him alive on Aug 12, 1930 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. K. Campbell M. D.

Aug 13, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Aug 14 1930
19 UNDERTAKER A. Howard Evans	ADDRESS 38 E Fayette

c. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59769

CERTIFICATE OF DEATH

X 145-001 ✓ E 59769

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ST. 14-27 WARD)

2—FULL NAME Maybelle V. C. Mahon

(a) RESIDENCE NO. Fort Hoyle, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: [illegible]

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Leo L. McMahon

ATE OF BIRTH (month, day, and year): May 18 1895

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	2	23	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

IRTHPLACE (city or town) (State or country): Kansas

10 NAME OF FATHER: John Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Quill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

Informant: Leo L. McMahon

(Address): Fort Hoyle Md

Filed 8 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-10-30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1930, to Aug. 10, 1930, that I last saw her alive on 8-10, 1930 and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH was as follows*:

General Peritonitis, following Caesarean Section

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-6-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Peake, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arlington Natl Cem. Va. DATE OF BURIAL: 8/14/30

20 UNDERTAKER: Edgar C. Finley ADDRESS: Fulton Fayette

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59770 | CERTIFICATE OF DEATH | 129 E 59770

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. ST. 16-68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Clara E Muth

(a) RESIDENCE NO. 1017 Ashburton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced: HUSBAND of (or) WIFE of Louis F. Muth

DATE OF BIRTH (month, day and year) Sept 27th 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Edward Pfeiffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Sauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Louis F. Muth

(Address) 1017 Ashburton Ave

C. HAMPSON JONES, M. D.

Filed Aug 13 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1930, to Aug. 12, 1930, that I last saw her alive on Aug. 12, 1930 and that death occurred, on the date stated above, at 1.35 p.m. (Standard)

The CAUSE OF DEATH* was as follows:

Hypertensive Cardiovascular Disease

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. W. Peake, M. D.

8/12, 1930 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Aug 15 1930

20 UNDERTAKER Wm F Cook

ADDRESS 1003 Eutaw St

—1 30—M. & T.—250 Bks.

E 59771 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59771

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2923 Riggs Ave ST. 16-67 WARD)

2-FULL NAME Mary Tydings

(a) RESIDENCE NO. 2923 Riggs Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Tydings

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER John Hannan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Connors

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

Informant Mary E. Thiel
(Address) 2923 Riggs Ave.

Filed AUG 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11th, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Aug 11, 1930, that I last saw her alive on Aug 10, 1930, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension
Myocarditis

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Albert Seagneth, M. D.

, 19 (Address) 244 S Fulton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 8/14 1930

20 UNDERTAKER E. J. Fanning & Son — ADDRESS 1886 Lafayette Ave.

Rec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59772

CERTIFICATE OF DEATH

194 E 59772

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1900 Bayard ST. 21-32 (WARD)

2—FULL NAME Jacob A Rambler

(a) RESIDENCE NO. 1900 Bayard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary K Rambler

6 DATE OF BIRTH (month, day, and year) April 19 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass factory

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Lowell Glass Co

9 BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Germany~~ England

Informant Goldie Rambler

(Address) 1900 Bayard St

Filed Aug 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12/30

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to Aug 12, 1930, that I last saw h~~im~~ alive on Aug 11, 1930 and that death occurred, on the date stated above, at 7.10 p m.

The CAUSE OF DEATH* was as follows:

Heart prostration

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) General paresis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Insanity.

(Signed) Raymond D Hudson, M. D.

Aug 12, 1930 (Address) 2708 Hallins Ferry Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Aug. 15 1930

20 UNDERTAKER: Harold D Cook

ADDRESS: 1003 West Baltimore St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59773

CERTIFICATE OF DEATH

(Rear 7th Calvert Cemetery)

17 / E 59773

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

City of Baltimore: (No. House of Refuge Grounds. St., 70-70 (Ward)

2 FULL NAME Charles M. Kinker.

(a) RESIDENCE NO. 280 Mt. Olivet Lane. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 7 mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed or divorced.
HUSBAND of Caroline Kinker.

6 DATE OF BIRTH (month, day, and year) December 14, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	88	7	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Pipe fitter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore?a.
(State or country)

PARENTS

10 NAME OF FATHER Christopher Kinker.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Catherine Arenz.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Caroline Kinker. (wife)
(Address) 280 Mt. Olivet Lane.

15 Filed , 193 C. HAMPSON JONES, M. D.
By Registrar

3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

External Hemorrhage.
Severance of left Brachial Artery with a knife. Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Kinkaid, M. D.

8/18, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westens Cem. DATE OF BURIAL: 8/14/1930

20 UNDERTAKER: Harry A. Wetzke ADDRESS: 401 Edmondson Ave.

30—M. & T.—100 B—50L

L 59774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88-13 L 59774

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp ST. 8-11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Jacob Radecki

(a) RESIDENCE NO 1109 S Streeper ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 45 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Kuon

DATE OF BIRTH (month, day, and year) June 12 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Simon Radecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mr Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Radecki

(Address) 109 S Streeper St

BIRTH 1930 C. HAMPSON JONES, M. D.
DEATH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: While running across the street ran into a motor auto

(a) ..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Multiple Fract Ribs & Chest Concussion Chest (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? O'Donnell & Boston

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Frame M. D.
Coroner

8/13 1930 (Address) 2439 Mt Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus cem. | DATE OF BURIAL Aug 15 1930

20 UNDERTAKER John J Weber 421 S Streeper | ADDRESS

1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59775

CERTIFICATE OF DEATH.

+ 91-002 E 59775

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST. 4 WARD 7)

2-FULL NAME Bro Aldrich
Normal Institute Md

(a) RESIDENCE No. Annandale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77(?)			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Records
(Address)

Filed 4 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13/30

17 I HEREBY CERTIFY, That I attended deceased from 6-11, 1930, to 8-13, 1930,

that I last saw h[illegible] alive on 8-13, 1930,

and that death occurred, on the date stated above, at 6 25 P. m.

The CAUSE OF DEATH* was as follows:

Benign hypertrophy prostate

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

8/13, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gunpowder Md

DATE OF BURIAL Aug 15 1930

20 UNDERTAKER Lloyd Kaiser

ADDRESS Laurel Md

M. & T.—100 B—50L.

E 59776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 59776

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

TY OF BALTIMORE: (No. 2243 Kirke Ave ST., 9-46 WARD)

2-FULL NAME Anna V. Hoffmann

(a) RESIDENCE NO 2243 Kirke Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

eegth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph L. Hoffman

ATE OF BIRTH (month, day, and year) Dec 27/1889

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	7	10	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Gus Steinmyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

nformant Joseph L. Hoffman

(Address) 2243 Kirke Ave

Filed Aug 17 1930 G. RAMSAY JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.

8/ 1 19 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL Aug 15 1930

20 UNDERTAKER Robt J Turner, 1942 Broadway

ADDRESS

c—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59777 124 E 59777

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (NO. 930 N Bond ST., 7-13 WARD)

2-FULL NAME Annie Jones

(a) RESIDENCE NO. 930 N Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	Married

If married, widowed, or divorced (or) WIFE of John Jones

ATE OF BIRTH (month, day, and year) June 7, 1895

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	35	2	5	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Mahaler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant John Jones husband (Address) 930 N Bond St

Filed AUG 15 1930 C. HAMPSON JONES, M. D. Registrar

4

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1930, to Aug 12, 1930, that I last saw h[illegible] alive on Aug 11, 1930, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Abscess of Liver

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Rupture of Abscess & Internal Hemorrhage (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Gosling, M. D.

8/13 1930 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reynolds Va

DATE OF BURIAL Aug 14, 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1720 Washington Ave

c.—1-30—M. & T.—250 Bks.

E 59778 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-09 E 59778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST 11-24 WARD)

2-FULL NAME Karl Metzler

(a) RESIDENCE NO. 215 W. Madison St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 8/7/[illegible] 1874

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) North Gen Floyd.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Karl Metzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miss I. Lauer

(Address) 215 W Madison St

4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13/30

17 I HEREBY CERTIFY, That I attended deceased from June 27, 19 30 to August 13 19 30.

that I last saw h[illegible] alive on August 13, 19 30,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Endarteritis Obliterans
Femoral Vein Thrombosis, Left
(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home Confinement

Did an operation precede death? Yes Date of Aug. 8, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) Meyer Miller Bayles, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 8/17/30, 19

20 UNDERTAKER Geo Leimbach

ADDRESS 2211 Gilmor St

c.—1-30—M. & T.—250 Bks.

Moton

HEALTH DEPARTMENT—CITY OF BALTIMORE

VE 59779

9779

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 N. Stoltenstr St. 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malcolm Moton

(a) RESIDENCE NO. 809 N. Stoltenstr St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

If married, widowed, or divorced HUSBAND of or) WIFE of Ann Moton

DATE OF BIRTH (month, day, and year) 1878

AGE: Years 52 | Months | Days | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer

BIRTHPLACE (city or town) (State or country): S. Carolina

10 NAME OF FATHER: Henry Chamberlain

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Sarah Moton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

Informant: Mrs. Catherine Parker

(Address) 809 N. Stoltenstr

Filed 4 1930 19 Registrar

H. JAMESON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17/30

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to Aug 17, 1930,

that I last saw h. alive on Aug 16th 1930

and that death occurred, on the date stated above, at 1 1/2 hr. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Acute Dilatation of Heart.

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Syphilis Aortic

(duration) 1 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? S. Carolina

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Lee Rice, M. D.

(Address) 824 Mt. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Aug 19 1930

20 UNDERTAKER: Sam W. Chase Inc

ADDRESS: Pratt & Mosher

...c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59780

E 59780

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
...ITY OF BALTIMORE: (No.) Navarre Apts. # 12. ST., 1700 Eutaw Place WARD) 14-20

2-FULL NAME Shefs Witz

(a) RESIDENCE NO. Navarre Apts. # 12. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of Moritz Witz

...ATE OF BIRTH (month, day, and year) Dec. 25th. 1865

...GE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	65	7	18	

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

...IRTHPLACE (city or town) Baltimore,
(State or country) Md.

10 NAME OF FATHER Joseph Grinsfelder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Rider

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

Informant Mrs. Moritz Witz
(Address) Navarre Apts. # 12.

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1918 to Aug. 13, 1930.

that I last saw h... alive on Aug. 13, 1930,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis,
Myocarditis
Cerebral Hemorrhage
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Morrison M. D.

19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem.	8/14/ 19 30
20 UNDERTAKER David Sondheim & Son	ADDRESS 1902 Eutaw Place

4-1930 ... 19 ... W. SHUCK NOSWITH Registrar

c.—1-30—M. & T.—250 Bks

59781 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 59781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14-30 Campbell St. (WARD)

2-FULL NAME Miss Juliett Campbell Guy

(a) RESIDENCE NO. Belmont Ave Catonsville ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Robert G. Guy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth A. Ahrens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant (Mrs) Mr John A. Dawson (Address) Catonsville Md

Filed AUG 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Aug 14, 1930, that I last saw h[illegible] alive on Aug 14, 1930 and that death occurred, on the date stated above, at 12 02 m.

The CAUSE OF DEATH* was as follows: (Day Cyst.

Myoma of uterus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Obesity (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Catonsville

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Examination - Autopsy

(Signed) Samuel McClenahan, M. D.

Aug 14 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Govans Mount Cemetery DATE OF BURIAL Aug. 16 1930

20 UNDERTAKER Stewart Mortuary Co ADDRESS Baltimore

—1-30—M. & T.—250 Bks.

E 59782

E 59782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. ____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) University Hospital ST., 1948 WARD)

2-FULL NAME George Warfield

(a) RESIDENCE NO. 1533 Ramsay ST., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced (HUSBAND of or) WIFE of George H. Warfield

DATE OF BIRTH (month, day, and year) May 16 1864

AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	66	2	27	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Columbus Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant George Warfield
(Address) 1533 Ramsay St

Filed 8-14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13/30.

17 I HEREBY CERTIFY, That I attended deceased from June 20th, 1930, to August 13, 1930.
that I last saw him alive on August 13th, 1930
and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of the Rt. Antrum
Cy Hignmore

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (Hypostatic)
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes. Date of 8/11/30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) George H. Yeager M. D.
8/13, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon
DATE OF BURIAL 8/16 1930
UNDERTAKER Walter Cook
ADDRESS 1219 E. Lond St

1-30—M. & T.—250 Bks.

E 59783 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 V E 59783

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 N Schroeder, ST. 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Martin

(a) RESIDENCE NO. 119 N Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced, (or) WIFE of: John Martin

DATE OF BIRTH (month, day, and year): - - 1868

AGE: Years 62 | Months — | Days — | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic Servant

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

BIRTHPLACE (city or town) (State or country): Unknown

NAME OF FATHER: Unknown

BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

MAIDEN NAME OF MOTHER: Unknown

BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant (Address): John Martin 119 N Schroeder St

Filed 4 1930 C. HAMPTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 11, 1930, that I last saw her alive on Aug 11, 1930, and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

Signed E. J. Howell M. D.

8/13 1930 (Address) 601 W Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Aug 14 1930

20 UNDERTAKER: Mrs Katie R. Williams

ADDRESS 327 N. Schroeder St

c.—2 29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 59784

59784

REGISTERED NO. .....

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Womans Hospital ST. 27-55 WARD)

2—FULL NAME Baby Boy Bond

(a) RESIDENCE NO. 3525 Oakmont ave ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if foreign birth? ✓ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

ATE OF BIRTH (month, day, and year) aug. 13 1930

GE	Years	Months	Days	If LESS than 1 day, 2 hrs. or ... min.
	✓	✓	✓	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

IRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Lewis M. Bond

11 BIRTHPLACE OF FATHER (city or town) Cockeysville
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Franklin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Mary A. Bond

(Address) 3525 Oakmont Ave

Filed ... 19 C. HAMPSON JONES, M. D.
Registrar

1 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from ~~Jan~~ aug 13, 1930, to ....., 19.....

that I last saw h/~~im~~ alive on aug 13, 1930

and that death occurred, on the date stated above, at 11 a. m. (A.L.S.T.)

The CAUSE OF DEATH* was as follows:

Prematurity

(doration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ✓
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schoch, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Richard's State Road

DATE OF BURIAL AUG 14 1930 19

20 UNDERTAKER C. Hampson Jones, M. D. Commissioner Health

ADDRESS

C.—1-30—M. & T.—250 Bks.

Baby Girl Levin (Susie)

E 59785

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59785

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 15-61 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Susie

(a) RESIDENCE NO. Sinai Hospital ST., 2204 Allendale Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Aug. 1. 1930

AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	—	—	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Samuel Susie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Krabick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London England.

Informant Samuel Susie Father.

(Address) 2204 Allendale Road

Aug 14 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Aug 14, 1930, that I last saw her alive on Aug 14, 1930, and that death occurred, on the date stated above, at 5 20 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Aug. 9. 1930

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Charles Robert Cohen, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Athey Wood Road

DATE OF BURIAL 8-14-1930

20 UNDERTAKER Jack Lewis, 1739 E Balto

ADDRESS

c.—1-30—M. & T.—250 Bks.

59786
3975-S

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59786

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 1-9 WARD)

2-FULL NAME Annie Miles

(a) RESIDENCE NO. Hanover - Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced (HUSBAND) of (or) WIFE of Jacob -

DATE OF BIRTH (month, day, and year) Dec 25-1891

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
38 39		7	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): N-Car -

10 NAME OF FATHER Richard Bradsham

11 BIRTHPLACE OF FATHER (city or town) (State or country): N-Car -

12 MAIDEN NAME OF MOTHER Matilda Bradsham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N-Car -

Informant Records Johns Hopkins Hospital

(Address)

Filed ..... 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1930, to Aug 13, 1930, that I last saw her alive on Aug 13, 1930, and that death occurred, on the date stated above, at 8 40 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hanover, Md

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Charles M McLane M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gamills a.a. Co. Md

DATE OF BURIAL: Aug 15 1930

20 UNDERTAKER: L. J. Burns & Son

ADDRESS: 1810 Madison Ave

c.—1-30—M. & T.—250 Bks.

59787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59787

REGISTERED NO. 51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3332 Chestnut Ave ST., 13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie R. Griffith

(a) RESIDENCE NO. 3332 Chestnut Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of William F. Griffith

DATE OF BIRTH (month, day, and year) Nov. 27-1863

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	66	8	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Co, Maryland

10 NAME OF FATHER Louis LeRoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Ann Rebecca Durant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant William F. Griffith

(Address) Meadow Rd. Ext. Co.

Filed Aug 4 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 7-1930 to Aug 12 1930,

that I last saw her alive on Aug 12 1930,

and that death occurred, on the date stated above, at 10 50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of left foot (duration) yrs. 14 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

8/13 1930 (Address) 846 W 36 St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

DATE OF BURIAL Aug 14 1930

20 UNDERTAKER Horace F. Burgee

ADDRESS 343 Falls Road

c.—1-30—M. & T.—250 Bks

E 59788 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59788

153

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) Mercy Hospital ST. 25-32 (WARD)

2-FULL NAME Mrs. Edmonia Thurman

(a) RESIDENCE NO. Cherry Hill ~~Baltimore~~ Westport ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4-3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married.

If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of Harry Thurman.

DATE OF BIRTH (month, day and year) April 27, 1887

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
43			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Frederick Schollian

11 BIRTHPLACE OF FATHER (city or town) (State or country) NY

12 MAIDEN NAME OF MOTHER Catherine Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Hospital Records

(Address)

[illegible] 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 11, 1930, to August 14, 1930,

that I last saw her alive on August 14, 1930,

and that death occurred, on the date stated above, at 8.50 9 m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Neck

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At her home.

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Appearance

(Signed) G. Brown Hollandsworth, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 8/18 1930

20 UNDERTAKER Albert L. Wiltz

ADDRESS 1 Chase St

...c.—1-30—M. & T.—250 Bks

59789

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 59789

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 911 Whitlock St. ST. 13-54 (WARD)

2-FULL NAME Mrs ~~Samuel~~ HERMINA Cohen

(a) RESIDENCE NO. 911 Whitlock St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

If married, widowed, or divorced
(or) ~~Husband~~ of Samuel Cohen

DATE OF BIRTH (month, day, and year) 1/30/1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~57~~ 57	7			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Hungary

10 NAME OF FATHER Adolph Greenhood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Henny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

Informant Samuel Cohen
(Address) 911 Whitelock St

Filed 4 1930. 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/30

17 I HEREBY CERTIFY, That I attended deceased from December 19 29 to Aug 14 19 30,

that I last saw her alive on Aug 14 19 30,

and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Generalized Carcinomatosis

Diabetes (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~Private residence~~

Did an operation precede death? yes Date of Nov 1929

Was there an autopsy? No

What test confirmed diagnosis? ~~Autopsy~~

(Signed) Francis M. Fuller, M. D.

19 (Address) 20 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Friendship

DATE OF BURIAL 8-15-1930

20 UNDERTAKER Jack Lewis, 1489 E Baltimore St

ADDRESS

30—M. & T.—100 B—50L

E 59790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 ✓

E 59790

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) Provident Hosp ST. 5-8 (WARD)

2-FULL NAME Leroy Black

(a) RESIDENCE NO 1352 N. Hugh St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) 1921

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9			

OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Aiken S C

10 NAME OF FATHER Sam Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C

12 MAIDEN NAME OF MOTHER Hannah Hendly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

Informant Sam Black

(Address) 135 N. Hugh St

Filed 1-4 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death the day stated above.

The CAUSE OF DEATH* was as follows: Child ran from behind parked Cars into front of moving auto

(duration) Instt. mos. ds.

CONTRIBUTORY (Secondary) Fract Femur Rt. Cerd. Lob (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In front of 131 N Hugh

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Dawson M. D. Coroner

1930 (Address) Biggs & Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aiken S. C

DATE OF BURIAL 8-14 1930

UNDERTAKER Byron Wright

ADDRESS 1218 N Eldersly St

...c.—1-30—M. & T.—250 Bks.

39527
E 59791
Ev. Surg.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59791

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

2-FULL NAME William Dickerson

(a) RESIDENCE No. 70 Lincoln Ave., Binghamton, N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (~~write~~ the word): Married

If married, widowed, or divorced
~~WIFE~~ HUSBAND of Ella B. Dickerson

DATE OF BIRTH (month, day, and year) May 21, 1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	2	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Executive

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): New York.

10 NAME OF FATHER Austin Dickerson

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.

12 MAIDEN NAME OF MOTHER Ella Bushnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Conn.

Informant (Address) Records JOHNS HOPKINS HOSPITAL

Filed 4 1930, 19 ... By C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 19 30, to Aug 14, 19 30,

that I last saw him alive on Aug 14, 19 30,

and that death occurred, on the date stated above, at 3:05 a. m.

The CAUSE OF DEATH* was as follows:

Multiple Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Edwards Suburbia

Did an operation precede death? Yes Date of 8-14-30

Was there an autopsy? Yes

What test confirmed diagnosis? - autopsy

(Signed) C. H. Buggs, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Binghamton, N. Y.

DATE OF BURIAL: 8/14 1930

20 UNDERTAKER: Stevenears & Son

ADDRESS: 8 S. N. Calvert St.

30—M. & T.—100 B—50L

E 59792

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59792

CERTIFICATE OF DEATH

REGISTERED NO. 101-48

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) President Hosp ST. 27-48 WARD

2-FULL NAME Charles Harris

(a) RESIDENCE NO. 5008 Bunagard ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of No

7 DATE OF BIRTH (month, day, and year) Mar 17 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Herman Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk

12 MAIDEN NAME OF MOTHER Iona Page

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

14 Informant Herman Harris

(Address) 5008 Bunagard

15 C. HAMPSON JONES, M. D. Registrar

4 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriologic

(Signed) H. Douglas Singleton M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL 8/10 1930

UNDERTAKER Daniel Easton

ADDRESS Fairfield

c.—1-30—M. & T.—250 Blks.

2 39502
E 59793

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 002
E 59793

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital ST 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO.

2-FULL NAME Edward Goski

(a) RESIDENCE NO. 2265 Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Oct-13-1929

AGE. Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Leo Goski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Mroz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant JOHNS HOPKINS HOSPITAL (Address)

Filed 4-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1930, to Aug 14, 1930, that I last saw him alive on Aug 14, 1930, and that death occurred, on the date stated above, at 7:55 m.

The CAUSE OF DEATH* was as follows:

Dysentery, acute bacillary

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. O. H. Warren, M. D.

, 19 (Address) Wolfe 5508 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Aug 16 1930

DATE OF BURIAL

20 UNDERTAKER John M Wieber Wm Chester

ADDRESS

c.—1-30—M. & T.—250 Bks

59794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 59794

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. 14-27 ST. WARD)

2-FULL NAME Elijah Lambert

(a) RESIDENCE NO. 236 Gilmor st. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 1895

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bus boy and waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 070

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Charles Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Josephine Braxton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Hospital Records

(Address)

FILED Jan 3 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1930

17

I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to Aug. 13, 1930,

that I last saw him alive on Aug. 13, 1930,

and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Lewis, M. D.

8-13, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Mt. Auburn Cemetery	Aug 30
20 UNDERTAKER	ADDRESS
Samuel Hendley & Bro.	

c.—1-30—M. & T.—250 Bks.

39534
R Surg.
E 59795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 E 59795

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 8-16

TY OF BALTIMORE: (No. ..... St. ..... WARD)

2-FULL NAME Tony Sears

(a) RESIDENCE NO. 811 Vine St. City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	unknown

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Mar. 14, 1877

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
53	4	30	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Buck Sears

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER — Giddings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant JOHNS HOPKINS HOSPITAL Records
(Address)

Filed ..... 19 1930 C. HARRY JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13-1930

17 I HEREBY CERTIFY, That I attended deceased from
Aug 1 , 1930, to Aug 13 , 1930,
that I last saw him alive on Aug 13 , 1930,
and that death occurred, on the date stated above, at 9⁰³ P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Tumor, spinal column

unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-3-30

Was there an autopsy?

What test confirmed diagnosis? X-ray.

(Signed) Fred W. Sick, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va	Aug 15 30
UNDERTAKER Samuel H. Fenderson	ADDRESS 538 Biddle

30—M & T.—100 B—50L

E 59796

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59796

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 607 Patterson Pl. (ST.) 14-20 (WARD)

2-FULL NAME Elias H. Jefferson

(a) RESIDENCE NO. 607 Patterson Pl. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel

DATE OF BIRTH (month, day, and year) Jan 23-1885

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	4	20	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Elias H. Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie A Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Minnie Jefferson

(Address) 607 Patterson

Filed ..... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Jacobs, M. D. Coroner

19 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. | DATE OF BURIAL Aug 15 1930

20 UNDERTAKER Samuel B. Brady | ADDRESS 1700 E Balto

AUG 15 1930

59797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 59797

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen. Hosp ST. 9-46 WARD)

2-FULL NAME Margaret M. Downes

(a) RESIDENCE NO. 1427 Homestead St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs 6 mos 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Downes

DATE OF BIRTH (month, day, and year) Feb. 5th 1895

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	35	6	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Charles B. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John L. Downes

(Address) 1427 Homestead St

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1930

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to Aug 13, 1930, that I last saw her alive on Aug 13, 1930 and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse Nephritis

(duration) Unknown mos 1 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Ashman M. D.

8/13, 1930 (Address) W. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL July 16 1930

20 UNDERTAKER J. J. Tucker & Sons

ADDRESS N. Pa Ave

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59798

CERTIFICATE OF DEATH.

124 E 59798

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2912 Clifton av ST. 15-61 (WARD)

2-FULL NAME Grace ~~E~~ D. Hachtel

(a) RESIDENCE NO. 2912 Clifton av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, ~~or divorced~~
HUSBAND of
(or) WIFE of Arthur W. Hachtel

6 DATE OF BIRTH (month, day, and year) Aug 26 1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
58	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Orlando Hafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Rebecca Reckard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Florence Price
(Address) 2912 Clifton av

15 Filed 8-15-1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1930

17 I HEREBY CERTIFY, That I attended deceased from 1926, to Aug 13, 1930, that I last saw h[illegible] alive on Aug 13, 1930, and that death occurred, on the date stated above, at 8.50 (Std) m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) Fred B Jewett, M. D.

8/14, 1930 (Address) 2516 Penn. av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Aug 16 1930

20 UNDERTAKER: Wm J. Jackson Sons

ADDRESS: Balto

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59799

59799

CERTIFICATE OF DEATH.

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1604 Aisquith ST. 9-16 (WARD)

2-FULL NAME Anna L. Shanahan

(a) RESIDENCE NO. 1604 Aisquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of John D. Shanahan

DATE OF BIRTH (month, day, and year) 9-19-1874

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	10	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (?)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Long Green Balto Co Md

10 NAME OF FATHER Patrick Kearney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant (Address) Miss L Shanahan 1604 Aisquith St

Filed AUG 15 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 24th, 1929, to Aug 13th, 1930,

that I last saw her alive on Aug 13th, 1930,

and that death occurred, on the date stated above, at 11.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) ? yrs. ? mos. ? ds. 1924

CONTRIBUTORY (Secondary) Carcinoma Breast Operation

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of July 1924

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) L. M. C. Parker, M. D.

8/14, 1930 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Long Green

DATE OF BURIAL 8/16/30

20 UNDERTAKER George J. Puth Inc

ADDRESS 1735 Hanover

c—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59800 — 90 E 59800

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 4026 Belle Ave ST. 15-63 (WARD)

2-FULL NAME Margaret E. Holmes

(a) RESIDENCE NO. 4026 Belle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female White	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Dennis R. Holmes

DATE OF BIRTH (month, day, and year) April 15, 1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Samuel Richmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eliza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Mr. Dennis R. Holmes

(Address) 4026 Belle Ave

Filed AUG 15 1930 C. HAMPSON JONES, M. D. Registrar

BY P.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 13, 1930,

that I last saw h... alive on Aug 13, 1930,

and that death occurred, on the date stated above, at 3 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral ~~Thrombosis~~ Embolism.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocarditis - absent

(duration) about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S Nisbett M. D.

, 19 (Address) 2220 Fenison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. — DATE OF BURIAL Aug. 19 30

20 UNDERTAKER Wm. A. Nisbett & Son — ADDRESS 1900 E. Eutaw St

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59801 — 117 — E 59801

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Madison Linden ST., 14-21 WARD)

2—FULL NAME Mr Richard E Gaither

(a) RESIDENCE NO. 1417 W. Fayette ST., WARD Balto. Md
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Richard Gaither

ATE OF BIRTH (month, day, and year) Aug 3 1895

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	11	20	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Terminal Warehouse

IRTHPLACE (city or town) (State or country) Balto

0 NAME OF FATHER Richard F. Gaither

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md

2 MAIDEN NAME OF MOTHER Annie Frott

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs. Katherine Gaither

(Address) 1717 W Fayette

Filed ... 19 ... Registrar

15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 13, 1930

that I last saw h alive on Aug 13, 1930

and that death occurred, on the date stated above, at 2:40 m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis
Peritonitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Coronary Embolism (duration) yrs. mos. 8 min

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 31, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Cronan, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Aug 16 1930

20 UNDERTAKER John Merrick

ADDRESS 210 E Preston St

H. [illegible] JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 59802

CERTIFICATE OF DEATH.

43 E 59802

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1728 E. Lanvale St. 16-7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Asa N. Parks

(a) RESIDENCE NO. 1728 E. Lanvale ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Parks

6 DATE OF BIRTH (month, day, and year): ? 1881

7 AGE: 49 (Years) (Months) (Days) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Captain of

(b) General nature of industry, business, or establishment in which employed (or employer): Ship-Seafaring

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hoopersville Md.

PARENTS

10 NAME OF FATHER: James H. Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hoopersville Md.

12 MAIDEN NAME OF MOTHER: Sally Quirk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hoopersville Md.

14 Informant (Address): Nathan J. Parks 1728 E. Lanvale St.

15 Filed AUG 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to Aug 14, 1930, that I last saw him alive on Aug 14, 1930 and that death occurred, on the date stated above, at 8.40 P.M. (Standard)

The CAUSE OF DEATH* was as follows:

Carcinoma of Submaxillary Glands (Both sides) "Suppurating"

(duration) about 1 yrs. mos ds.

CONTRIBUTORY (Secondary) First started in lower left gum (duration) yrs. 9 mos. ds.

Fourth finger left hand when I was 1 yr old

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Macroscopic

(Signed) E. C. Carman, M. D.

8-15-1930 (Address) 1701 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hoopersville Md.

DATE OF BURIAL: Aug 16 1930

MGR. UNDERTAKER: Charles J. Jones

ADDRESS: 1024 Eastern Ave

...c.—1-30—M. & T.—250 Bks

59803

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59803

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 185 W Saratoga St. 16-16 WARD)

2-FULL NAME Pearl Harris.

(a) RESIDENCE NO. 185 W Saratoga St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

If married, widowed, or divorced (or) WIFE of Edward Harris

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

BIRTHPLACE (city or town) (State or country) D. C.

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Isaac Redden

(Address) 2 [illegible]

Filed ... 19 ... HAMPSON JONES, M. D. Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13-30

17 I HEREBY CERTIFY, That I attended deceased from 8-11-, 1930, to 8-13, 1930,

that I last saw her alive on 8-12, 1930,

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Total Insufficiency Acute Dilatation of Heart.

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. L. Jackson M. D.

8/IX. 1930 (Address) 600 N Carlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Anderson, S C.

DATE OF BURIAL Aug 15, 1930

20 UNDERTAKER Mrs Katie R Williams

ADDRESS 322 N Schroeder St

Sec.—1-30—M. & T.—250 Bks.

E 59804 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59804

CERTIFICATE OF DEATH.

23

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 28-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Sneider

(a) RESIDENCE NO. 4200 Maine Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of —

DATE OF BIRTH (month, day, and year) Jan 1916

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	7		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Louis Sneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Africa

12 MAIDEN NAME OF MOTHER Sarah Trashman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant J. Lewis

(Address) 1731 E Balto

Filed AUG 15 1930 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to Aug 15, 1930, that I last saw h alive on Aug 15, 1930, and that death occurred, on the date stated above, at 3a. m. 8 57

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Hernia tomy Yes Date of 7/22/30

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) Lucien B Kirk, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Beth Israel, Woodlawn Hill. DATE OF BURIAL Aug 17 1930

20 UNDERTAKER Jos. Lewis, ADDRESS 1734 E Balto

c.—2-29-28—L. F. S.—500 Bks.

59805

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59805

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH Bon Secours Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) ST. 8-17 (WARD)

2—FULL NAME Joseph F. Kelly

(a) RESIDENCE NO. 1649 E. North Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Sept 24-75

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	10	20	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Luke Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Hosp Records

(Address)

Filed AUG 15 1930 19.. C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Aug 14, 1930, that I last saw h[illegible] alive on Aug 10, 1930 and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx

Duration of Pregnancy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchiectasis & Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Jones, M. D.

Aug 19 1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Aug 16 1930

UNDERTAKER

ADDRESS Rida Woodward 911 Gramont Ave

Rec.—1-12-23—M&T—500 Blks.

59806

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59806

CERTIFICATE OF DEATH. 100-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 E. Madison ST. 7-13 WARD)

2-FULL NAME LeRoy Taylor Hanes

(a) RESIDENCE NO. 1512 E. Madison ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	S

If married, widowed, or divorced HUSBAND of or) WIFE of .....

DATE OF BIRTH (month, day, and year) May 28, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) Balto
(State or country) Md

10 NAME OF FATHER Thomas Hanes

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Helen Taylor

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

Informant Helen Hanes
(Address) 1512 E. Madison St

Filed 5-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 14, 1930, that I last saw h~~e~~ alive on Aug 14, 1930, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* ~~was~~ as follows:

Bronchs Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C B LeCompte, M. D.

, 19 (Address) 1113 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Aug 16 1930

20 UNDERTAKER Lotter Gross ADDRESS 1402 Eastlandore

.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59807

CERTIFICATE OF DEATH

129 E 59807

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 1279 William ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F. Whelttle

(a) RESIDENCE NO. 1279 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

married, widowed, or divorced ___

HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) Oct. 24-1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	9	21	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment In which employed (or employer) None

(c) Name of employer

IRTHPLACE (city or town) State or country) Balto Md

0 NAME OF FATHER Francis M. Whelttle

1 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

2 MAIDEN NAME OF MOTHER Nora Roan

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Nora Whelttle

(Address) 1279 Williams St

Filed ..., 1930. E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug, 19 29, to Aug 14, 19 30, that I last saw h[illegible] alive on Aug 13, 19 30, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Uremia chronic

Immediate cause death

Broncho-pneumonia

(duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary) Osteomyelitis

(duration) 35 yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Hayward, M. D.

19 (Address) 1129 N Calvert

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Aug. 16 1930

20 UNDERTAKER Margaret E. Flynn

ADDRESS 1111 Lighton

—1-30—M. & T.—250 Bks.

39717
Ped. 59808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Ped. 59808

161-0

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Ursula Vaughan

(a) RESIDENCE NO. 923 Shuter St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Child

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 3, 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Milton Vaughan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed AUG 15 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 13, 1930, that I last saw h.r alive on Aug 13, 1930, and that death occurred, on the date stated above, at 5 35 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

8/14, 1930 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL Aug. 15 1930

20 UNDERTAKER Wm J. H. Locks

ADDRESS 1302 Jefferson St

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59809 E 59809

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

TY OF BALTIMORE: (NO. ST. 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archibald McGee

(a) RESIDENCE NO. 100 N. Front ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of -

DATE OF BIRTH (month, day, and year) May 17, 1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Scotland

10 NAME OF FATHER David

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Jeannette McK[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

Informant Records of

(Address) Balto. City Hospitals

Dec 5 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11-30

17 I HEREBY CERTIFY, That I attended deceased from 7-26-30, 19, to 8-11-30, 19,

that I last saw him alive on 8-11-30, 19,

and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Podget, M. D.

8-13 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL AUG 15 1930

UNDERTAKER Commissioner Health

ADDRESS

ec.—1-30—M. & T.—250 Bks.

E 59810

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59810

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto City Hospl. 7-27

TY OF BALTIMORE: (No. Balto Md. St. or WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Kerg

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	Unknown

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1873

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

BIRTHPLACE (city or town)
(State or country) N. Carolina ?

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

Informant Records Balto City Hosp.
(Address)

Filed 5 1930, 19

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1928, to Aug 12, 1930,
that I last saw her alive on Aug 12, 1930
and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Senile Psychosis with Deteriorating (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Harry F. Corbett, M. D.

8/12, 1930 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL AUG 15 1930

20 UNDERTAKER Commissioner Health

ADDRESS

For Wm. S. HUSSELL

c.—1-30—M. & T.—250 Bks

E 5981 HEALTH DEPARTMENT—CITY OF BALTIMORE E 5981

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals ST., 16-27 WARD

TY OF BALTIMORE: (No.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mack

(a) RESIDENCE NO. 633 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Married

If married, widowed, or divorced (or) HUSBAND of / WIFE of Sarah

ATE OF BIRTH (month, day, and year) Feb. ?

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55?			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Whist Co.

(State or country) W. Va.

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Lizzie Crowley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) W. Va.

Informant Records of

(Address) Balto. City Hosp.

C. HAMPSON JONES, M. D. Registrar

1930 Dec. 15-14

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13-30

17

I HEREBY CERTIFY, That I attended deceased from 8-6-30, 19, to 8-13-30, 19,

that I last saw him alive on 8-13-30 19

and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

Auricular fibrillation

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Dilotation of stomach, acute (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? Ye

What test confirmed diagnosis? Autopsy

(Signed) Dave Podgel, M. D.

8-14, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvary

DATE OF BURIAL 8-16 1930

ADDRESS 916

20 UNDERTAKER Samuel Carson

Beard

c—1-30—M. & T.—250 Bks.

39781
E 59812

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59812

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST. 7-9 + 57 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Steinberg

(a) RESIDENCE NO. 1787 Peabody St ST., ... WARD Memphis Tenn
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced (HUSBAND of or) WIFE of Rose Goldsmith

DATE OF BIRTH (month, day, and year) March 31-1870

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	60	4	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Tobacco

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Tenn —
(State or country)

10 NAME OF FATHER Saul Steinberg

11 BIRTHPLACE OF FATHER (city or town) Ger —
(State or country)

12 MAIDEN NAME OF MOTHER Hanna Unna

13 BIRTHPLACE OF MOTHER (city or town) Ger —
(State or country)

Informant Rec'd 8-15 Mrs. Rose Steinberg
(Address) Memphis, Tenn

C. HAMPSON JONES, M. D.

Filed ..... 19.. Registrar .....

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Aug 15, 1930, that I last saw him alive on Aug 15, 1930, and that death occurred, on the date stated above, at 2.50 a m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus.
Uremia
(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) H H Smith M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Memphis, Tenn	Aug 15 19 30
19a UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1900 Eutaw Pl

2-29-28—1. P. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59813 57 E 59813

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 19-26 ST., WARD)

2—FULL NAME J. Thomas Eisenhauer

(a) RESIDENCE NO. 1 N. Carey St. Carey apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of → Mrs Eisenhauer

7 DATE OF BIRTH (month, day, and year) Apr. 6 1873

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56	57	4	5	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Capt. of Police Montgomery Ward Agency 2 yrs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) Frederick (State or country) Md.

11 NAME OF FATHER Joseph Eisenhauer

12 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

13 MAIDEN NAME OF MOTHER Mary Meture

14 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

Informant Hosp. Records

(Address)

Filed 5-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1930, to Aug 14, 1930.

that I last saw him alive on Aug 14, 1930

and that death occurred, on the date stated above, at 11: P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Myocarditis (Chronic).

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? unk.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Path. & Labs.

(Signed) Robert V. Clements M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Frederick DATE OF BURIAL 8/17 1930

20 UNDERTAKER Wilhelm Cook ADDRESS 1217 E Pratt St

ec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59814 — CERTIFICATE OF DEATH. — 59814

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 35 W. Preston St. (Ward) 11-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Caroline E. Louis Goldsborough

(a) RESIDENCE NO. 35 W. Preston St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced: (or) WIFE of Louis E. Goldsborough

DATE OF BIRTH (month, day, and year): Sept. 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: at home

BIRTHPLACE (City or town) (State or country): Md.

10 NAME OF FATHER: John W. Chrisman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Catherine M. Mickum

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md.

Informant: Louis E. Goldsborough

(Address) 35 W. Preston St

C. HAMPSON JONES, M. D. Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 13 1930

17 I HEREBY CERTIFY, That I attended deceased from August 11, 1930, to August 13, 1930, that I last saw her alive on August 13, 1930, and that death occurred, on the date stated above, at 7 25 P m.

The CAUSE OF DEATH* was as follows:

Osteitis deformans (Paget's disease) multiple bones.

(duration) 20 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) lobar pneumonia 5 days. arteriosclerosis total cardiac arrhythmia (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical, lab. + X Ray methods

(Signed) Frank H. Smith Jr. M. D.

8/13, 1930 (Address) 927 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 8/16 1930

20 UNDERTAKER: W. M. Cook

ADDRESS: 1217 Eutaw St

Spec.—7-17-26—A Co.—200 Bks.

E 59815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

#6 E 59815

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 703 Eaton Ave St. 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Stump.

(a) RESIDENCE NO. 783 Eaton Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Stump

6 DATE OF BIRTH (month, day, and year): Aug. 11 - 1870

7 AGE: Years 60 Months 0 Days 4

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Edward Bendemeyer

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Emma Boxter

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant: Mrs. Kathrine Bigham

(Address) 521 Eaton Ave.

15 Filed 5 1930 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1930 Aug. 15

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to Aug. 15, 1930, that I last saw her alive on Aug. 14, 1930, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? Yes Date of 6-3-29

Was there an autopsy? No

What test confirmed diagnosis? Tissue Diagnosis

(Signed) K. B. Boyd, M. D.

, 19 (Address) 1040 Madison St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

Date of Burial: 8/18 1930

20 UNDERTAKER: Anthony Loeb

ADDRESS: 1219 Eutaw St

...ec.—1-30—M. & T.—250 Bks.

E 59816 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59816

CERTIFICATE OF DEATH.

+181-002

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ST. 7-9 WARD)

2-FULL NAME Florence Garrison

(a) RESIDENCE NO. 20 E. Mt Vernon Place ST., WARD Wash. D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): single

If married, widowed, or divorced (HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Oct. 1872

AGE: 57 Years 7 Months 27 Days — If LESS than 1 day, hrs. or min.

58

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) D.C.

10 NAME OF FATHER Tom Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emma Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

C. HAMPSON JONES, M. D.

1930 Aug. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15-1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Aug 15, 1930, that I last saw h[illegible] alive on Aug 15, 1930, and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema and shock following ether anesthesia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hydropneumo thorax, right

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) James Bordley III, M. D.

8-15, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C. — DATE OF BURIAL Aug 16 1930

20 UNDERTAKER John A. Mitchell & Sons — ADDRESS 1900 Eutaw Pl.

c.—1-30—M. & T.—250 Bks

E 59817 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 49 E 59817

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Balto. City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. ST. 24-34 WARD)

2-FULL NAME Mary Miller

(a) RESIDENCE NO. 719 E. Fort ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of ? -

ATE OF BIRTH (month, day, and year) February 19, ?

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	73			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Jake Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Records of Balto. City Hosp.

Filed 1-5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13-30

17 I HEREBY CERTIFY, That I attended deceased from 8-11-30, 19..., to 8-13-30, 19..., that I last saw her alive on 8-13-30, 19..., and that death occurred, on the date stated above, at 10:55 A.M.

The CAUSE OF DEATH* was as follows:

Coycinoma of urinary bladder

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Secondary anaemia (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

8-13, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dowdall Park

20 UNDERTAKER J. F. Sakaroff Sons

DATE OF BURIAL 8/16 1930

ADDRESS 1518 Taylor Ave

E 59818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59818

REGISTERED NO. 124

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. Jew Hosp. (St.) 16-27 (Ward)

2-FULL NAME Georgianna Horner

(a) RESIDENCE NO. 1938 W Lanvale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married -

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Married

DATE OF BIRTH (month, day, and year) Feb 6 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	52	6	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.... House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Frederick Co Maryland -

10 NAME OF FATHER Ezra Little

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Willie J Horner (Address) 1935 W Lanvale St

15 Aug 16 1930 . 19 C. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 10 . 19 30 , to Aug 16 , 19 30 , that I last saw h er alive on Aug 16 , 19 30 and that death occurred, on the date stated above, at 12.25 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerulo Nephritis

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H W Wagner , M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pinehurst Cemetery Carroll Co Md

DATE OF BURIAL Aug 18 1930

20 UNDERTAKER J F Ehrie Westminster Md

ADDRESS

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59819 E 59819

CERTIFICATE OF DEATH.

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 1512 E. Preston ST., 8 — WARD) 8-17

2-FULL NAME George M. Hardester

(a) RESIDENCE NO. 1512 Preston St ST., 8 — WARD

(Usual place of abode) (If non-resident give city or town and State)

eagth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ole.	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah R. Hardester.

ATE OF BIRTH (month, day, and year) Nov. 14-1852

GE 77 Years	8 Months	25 Days	If LESS than 1 day, ...hrs. or....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Printer

(b) General nature of industry, business, or establishment in which employed (or employer) Box Printing 063

(c) Name of employer Bartgis Bros. Co.

IRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Benjamin Hardester

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER Cornelia Wrightx

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

Informant Harry B Hepler

(Address) 151- E Preston St.

Filed 6 1930 C. HAMPSON JONES, M. D., Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14-1930

17 I HEREBY CERTIFY, That I attended deceased from Augl 10 —, 1930, to Aug. 14 —, 1930, that I last saw him alive on " " , 1930, and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. 2 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby M. D.

8/14/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 18 1930
20 UNDERTAKER Henry Hauck Sons Inc	ADDRESS 1301 E Eager St

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59820

E 59820

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 1002 S. Hanover ST. 19-28 (WARD)

2-FULL NAME Elizabeth Johnson

(a) RESIDENCE NO. 100 S. Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 75 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of —

ATE OF BIRTH (month, day, and year) Feb 10th 1855

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	6	3	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Moses Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Margaret Johnson

(Address) 320 Glendale Ave

C. HAMPSON JONES, M. D.

Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13/30

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to Aug 13 1930, that I last saw h~ alive on Aug 13 1930 and that death occurred, on the date stated above at ....m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic Hypertension

(duration) yrs. 4 mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Jas L Kennedy M. D.

Aug 15 1930 (Address) 1729 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 16 1930
UNDERTAKER	ADDRESS
F. S. Hufnut	1650 W Baltimore St

c.—1-30—M. & T.—250 Bks.

E 59821 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59821

CERTIFICATE OF DEATH. 107-003

1-PLACE OF DEATH Sinai Hosp. 6-10 REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME William Heinbuch

(a) RESIDENCE NO. 411 N Port St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Me	White	single

If married, widowed, or divorced HUSBAND of or) WIFE of — — —

DATE OF BIRTH (month, day, and year) Aug. 12. 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	0	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer United Ry + Elect. Co.

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John Heinbuch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Weimel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant George Heinbuch (Brother)
(Address) 411 N. Port St.

Filed 6 1930, 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-14-30

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 14, 1930, that I last saw him alive on Aug 14, 1930, and that death occurred, on the date stated above, at 7 AM. 8

The CAUSE OF DEATH* was as follows:

Non tuberculous Abscess of Lung

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Obs.

(Signed) Milton Bosley, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Cemetery — DATE OF BURIAL Aug. 17 1930

20 UNDERTAKER Henry Sander & Sons-Inc — ADDRESS Baltimore St. & Broadway.

c.—1-30—M. & T.—250 Bks.

In Columbus 115 Broadway

59822 HEALTH DEPARTMENT—CITY OF BALTIMORE 59822

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 2834 Pusbury ST. 15-68 WARD)

2-FULL NAME Robert G Kane

(a) RESIDENCE NO. 2834 Pusbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) June 15, 1930

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Maurice Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Ora M Gantz Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Maurice H Kane

(Address) 2834 Pusbury St

6 1930 ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1930

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1930, to August 15, 1930, that I last saw h[illegible] alive on August 15, 1930, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Aug 16 19 30 (Signed) Joseph L. Valentine M. D.

(Address) 1X S. Wood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Aug 18 19 30.

ADDRESS

20 UNDERTAKER William Cook

Cor.—10-10-29—A Co.—100 Bks.

E 59823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 59823

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 217 N. Parrish St. St., 19-07 Ward)

2-FULL NAME James Augustus.(C)

(a) RESIDENCE NO. 217 N. Parrish St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced: HUSBAND of (or WIFE of) Annie Augustus.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	68	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Augustus.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Caroline Brown.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Carroll Co. Md.

14 Informant Annie Augustus.(C) wife.
(Address) 217 N. Parrish St.

19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Einhardt, M. D.

8/15 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Aug. 16 1930

20 UNDERTAKER: Mrs. Peter R. Williams

ADDRESS 321 Saratoga

8 1930

HARRISON [illegible] M. D.

Spec.—1-12-23—M&T—500 Blks.

E 59824

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59824

58-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 Dolphin ST. 1-24 WARD)

2-FULL NAME Mildred E. Brown

(a) RESIDENCE NO. 704 Dolphin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 27-1917

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	7	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER David Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hilda Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant (Address) Julia A. Wheeler 704 Dolphin Street Baltimore, Md.

Filed ..... 19 ..... Registrar

6-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Aug 13, 1930.

That I last saw h[illegible] alive on Aug 13, 1930.

and that death occurred, on the date stated above, at 7.00 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) ... yrs. 2 mos ... ds.

Ex Sanatorium

CONTRIBUTORY (Secondary) (duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Aug 14 1930 Signed J. D. Stinchcomb M.D.

(Address) 1413 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug 17 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 130 Preestman St

Cor.—10-10-29—A Co.—100 Bks.

C 59825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 C 59825

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1732 Jackson St. 2434 Ward)

2-FULL NAME Rose L. Helms.

(a) RESIDENCE NO. 1732 Jackson St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 0 mos. 28 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ (or) WIFE of Thomas J. Helms.

6 DATE OF BIRTH (month, day, and year) July 17, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	0	28 27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael J. Carey.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann Carr.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Mary E. Helms. (daughter)
(Address) 1732 Jackson St.

Filed ..... 19 ..... Registrar

16 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.

8/15, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL aug 18 1930

20 UNDERTAKER J. J. Fahey & Sons

ADDRESS 1318 Light

...—1-30—M. & T.—250 Bks.

39507

E 59826

HEALTH DEPARTMENT—CITY OF BALTIMORE

VS 59826

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6-4 St., WARD)

2-FULL NAME Hester Ward

(a) RESIDENCE No. 1631 Jefferson St., 81 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md —

10 NAME OF FATHER John Hand

11 BIRTHPLACE OF FATHER (city or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER Harriet Parker

13 BIRTHPLACE OF MOTHER (city or town) Md —

(State or country)

Informant (Address) Records — JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M. D.

..... 19 ..... Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1930, to Aug 15, 1930, that I last saw Mrs alive on Aug 15, 1930, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Perforation of rectum with intraperitoneal hemorrhage and generalized peritonitis

Bronchopneumonia

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Myomata uteri-Adenocarcinoma Cyst right Rectal Stricture (duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of Aug 13, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. S. Everett, M. D.

8/15, 1930 (Address) The Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westview Md	Aug 18, 30
20 UNDERTAKER	ADDRESS
D. T. Williams	1516 McCulloh St

30—M. & T.—100 B—50L

E 59827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 59827

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 8-40 (WARD)

2-FULL NAME Mary Virginia Anderson

(a) RESIDENCE NO 3111 Lawnview Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	S

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 22/1924

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	11	22	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Charles A. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary V. Cliff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

Informant Charles C. Anderson

(Address) 3111 Lawnview Ave

C. HAMPSON JONES, M. D. Registrar

AUG 16 1930, 192 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ruptured Appendix

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 8/14/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

8/15/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Aug. 18 1930

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert St.

c—1-30—M. & T.—250 Bks.

E 59828 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59828

CERTIFICATE OF DEATH.

88

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) 212 Lambeth Road ST., 19 Guilford WARD)

2-FULL NAME Emma Hough

(a) RESIDENCE NO. 212 Lambeth Road ST., Guilford WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Single

married, ~~widowed~~, or ~~divorced~~
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Feb 28th 1875

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	5	18	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Baltimore
(State or country) Md

0 NAME OF FATHER Samuel J Hough

1 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore Md

2 MAIDEN NAME OF MOTHER Mary Edmonson

3 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore Md

Informant Mrs Poe
(Address) same this

C. HAMPSON JONES, M. D.
Registrar

Rec'd AUG 1930 By Dr

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1930

17 I HEREBY CERTIFY, That I attended deceased from August 11th, 1930, to August 16th, 1930, that I last saw her alive on August 15, 1930, and that death occurred, on the date stated above, at about 4 30 A m.

The CAUSE OF DEATH* was as follows:

Subacute Infective Endocarditis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Secondary Anaemia

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Blood culture taken but were negative

(Signed) Thomas B. Fletcher, M. D.

, 19 (Address) 1201 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Aug 18 1930

20 UNDERTAKER Henry Gardiner's Sons Co

ADDRESS Baltimore Md

...—8-16-29—L. F. S.—100 Bks.

E 59829

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 59829

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 435 Augusta Ave ST. 10-21 WARD)

2—FULL NAME Frances C. Hoot

(a) RESIDENCE NO. 435 Augusta Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles W. Hoot

DATE OF BIRTH (month, day, and year): Oct 20, 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

BIRTHPLACE (city or town) (State or country): Baltimore Maryland

10 NAME OF FATHER: Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

Informant: Mr. Charles W. Hoot

(Address): 435 S. Augusta Ave.

Filed ..... 19 ..... C. CLARKSON JONES, M. D., Registrar

6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1930, to Aug 14, 1930, that I last saw h alive on August 12, 1930, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (coma)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Paralysis agitans (?)

(duration) 7-8 yrs. mos. da.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jack J. Singer, M. D.

8/15 1930 (Address) 1220 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Aug. 16 1930

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 West Baltimore St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59830

CERTIFICATE OF DEATH.

38 E 59830

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1716 E. Eager St. 9-13 Ward)

2-FULL NAME Curtis I. Simpson

(a) RESIDENCE NO. 1716 E. Eager St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1930

7 AGE: Years 1 Months 10 Days 11 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Curtis Simpson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Bessie Gilmer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Curtis Simpson

(Address) 1716 E. Eager St.

15 Filed ..... 19 ..... Registrar

6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bowel Obstruction

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Probably Syphilis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. [illegible] M. D.

(Coroner)

8/16/30 (Address) 508 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. Date of Burial Aug 16 1930

20 UNDERTAKER Mrs K. E. Elliott ADDRESS 1625 Walbrook

c.—1-30—M. & T.—250 Bks

E 59831 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59831

100-0

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Provident Hospital S. 10-14 WARD)

2-FULL NAME James Washington

(a) RESIDENCE No. 872 McKeny ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	colored	single

If married, widowed, or divorced
HUSBAND of
or) WIFE of —

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 240

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town)
(State or country) N C

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant
(Address)

Filed ..... 19 ..... Registrar

1930 THE MORGUE.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to Aug 5, 1930, that I last saw h— alive on Aug 5, 1930, and that death occurred, on the date stated above, at 12 55 A.M.

The CAUSE OF DEATH* was as follows:

Lung Abscess

Bronchopneumonia

(duration) about 1 mos ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical + X-ray

(Signed) Arnold M St Clair M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL AUG 15 1930

20 UNDERTAKER Commissioner Health

ADDRESS

HAMPSON JOHNS, M.D.

c.—1-30—M. & T.—250 Bks

E 59832 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59832

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clent Gibson

(a) RESIDENCE No. 1100 Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

If married, widowed, or divorced
(a) HUSBAND of
or) WIFE of —

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33			

OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) C H D

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pittsburg Pa

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

Informant Bob Epps (friend) 11 30 P.M. ST

(Address) (Youngstown Ohio City)

1930 THE MORGUE

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-30

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to Aug 6, 1930,

that I last saw him alive on Aug 3 0, 1930,

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) about yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Lab

(Signed) Carroll M Stelain, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

NS HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

C. HAMPSON JONES, JR.

Commissioner Health

AUG 15 1930

c.—1-30—M. & T.—250 Bks.

39479
Ped.
59833

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 59833

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

JOHNS HOPKINS HOSPITAL

TY OF BALTIMORE: (NO. ST 10-44 WARD)

2-FULL NAME Clayton Planter

(a) RESIDENCE NO. 1410 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Child

If married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day.....hrs. or .....min.
		2	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Harrison Planter

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Helen Brown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9-1930

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 9, 1930,

that I last saw him alive on Aug 9, 1930,

and that death occurred, on the date stated above, at 1:15 a m.

The CAUSE OF DEATH* was as follows:

acute nutritional disturbance

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert O. Y. Wearn, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

HAMPSON JONES, M. D. Commissioner of Health.

8 1930

...—1-30—M. & T.—250 Bks.

39716
B 39834

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59834

CERTIFICATE OF DEATH.

86-30

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 10-14 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hampton

(a) RESIDENCE NO. 1120 Pulaski St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W. Fute	Child

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) July 24, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Wm. Hampton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mildred Links

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

...G 1930 ..., 19... Registrar

C. HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 13, 1930, that I last saw he alive on Aug 13, 1930, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

acute mastoiditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8/12/30

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) V. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL AUG 16 1930 19...

20 UNDERTAKER JOHNS HOPKINS HOSPITAL

ADDRESS

Baltimore Health

—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59835

CERTIFICATE OF DEATH.

161 E 59835

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1228 Hanover ST. 23 WARD 23-31

2-FULL NAME Infant of Mr & Mrs Herbert S. Hoffman

(a) RESIDENCE NO. 1228 Hanover ST. 23 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) aug 5/30

AGE	Years	Months	Days	If LESS than 1 day 2 hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto
(State or country) Md

10 NAME OF FATHER Herbert S. Hoffman

11 BIRTHPLACE OF FATHER (city or town) Calvert Co.
(State or country) Md

12 MAIDEN NAME OF MOTHER Lucy M. Ellison

13 BIRTHPLACE OF MOTHER (city or town) Ark.
(State or country) Ark

Informant Herbert S Hoffman
(Address) 1228 Hanover

Filed AUG 16 1930 G. HAMPSON JONES, M. D. Registrar

6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 19 30

17
I HEREBY CERTIFY, That I attended deceased from aug 15, 1930, to aug 15, 1930
that I last saw h alive on aug 15, 1930
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(5 mo. in utero)
(Duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Prematurity
(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

8/16/30 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr Richmond State Board

DATE OF BURIAL: AUG 16 1930

20 UNDERTAKER .....

ADDRESS .....

Commissioner Health.

c.—1-30—M. & T.—250 Bks.

39832
E 59836

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST., 7-4 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.

2-FULL NAME Marie King

(a) RESIDENCE NO. Smithsburg Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) Apr-28-1910

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	3	18	17

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Worx

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

IRTHPLACE (city or town) Pa
(State or country)

10 NAME OF FATHER John King

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Miner

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant JOHNS HOPKINS HOSPITAL Records
(Address)

6 1930 C. HAMPSON JONES, M. D.
Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-15-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug-15, 1930, that I last saw her alive on Aug 15, 1930, and that death occurred, on the date stated above, at 9 25 p.m.

The CAUSE OF DEATH* was as follows:

Acute anterior Poliomyelitis with ascending motor paralysis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Bulbar Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Emil B Cebadey M. D.

, 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Leitersburg Md

DATE OF BURIAL 8/7 1930

20 UNDERTAKER Walter J. Stone

ADDRESS Hagerstown Md

c.—1-30—M. & T.—250 Bks.

2-3952-6
E 59837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 60-001 E 59837

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST., 7-9 WARD)

2-FULL NAME Thomas Slick

(a) RESIDENCE NO. Oklahoma City Okla ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced (a) HUSBAND of (or) WIFE of Bernice Fraties

DATE OF BIRTH (month, day, and year) Oct. 12 1883

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	10	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oil Producer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER John Slick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant JOHNS HOPKINS HOSPITAL Records
(Address)

Filed 1 7 1930 H. HAMPTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 16, 1930, that I last saw him alive on Aug 16, 1930, and that death occurred, on the date stated above, at 3 14 A m.

The CAUSE OF DEATH* was as follows:

Cerebral accident

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug. 5, 1930

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) G. B. Hunt, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clarion, Penna

DATE OF BURIAL Aug 19 1930

20 UNDERTAKER John A. Mitchell & Sons

ADDRESS 1200 Eutaw Pl.

C.—1-30—M. & T.—250 Bks.

E 59838 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59838

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland University Hospital

TY OF BALTIMORE: (No. ST. 11-24 WARD)

2-FULL NAME James Alvin Ford

(a) RESIDENCE NO. Lothian Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) Nov. 16, 1930

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5 months		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) W. Va.

10 NAME OF FATHER J. A. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

Informant (Address) P. A. Goodwin Lothian

Filed AUG 17 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from 12:30 A.M. Aug 4, 1930, to 8:30 A.M. Aug 16, 1930,

that I last saw him alive on August 16, 1930,

and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Volvulus: (with malnutrition) for 1 month

33 hrs (duration) yrs. mos da.

CONTRIBUTORY (Secondary) Obstruction, intestinal

33 hrs. (duration) yrs. mos da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 14, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. H. Lynch, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herring Creek Church

DATE OF BURIAL Aug 17 1930

20 UNDERTAKER P. A. Goodwin

ADDRESS Lothian

E 59839

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 65-001

CERTIFICATE OF DEATH.

E 59839
REGISTERED NO.

1-PLACE OF DEATH West Balt. Gen. Hosp.

CITY OF BALTIMORE: (No.) Rayner & Dukeland St. 16-68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Groves.

(a) RESIDENCE NO. 1621 First Ave. Elkgrove Park Pa. ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. Cs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) March 16, 1866

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	64	5		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Adams Town.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant (Husband)

(Address)

Filed Aug 17 1930 19

C. HAMPSON JONES, M. D. Registrar

By AK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 19 30

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to Aug 16, 1930,

that I last saw h[e] alive on Aug 16, 1930

and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia.
C Terminal cardiac dilatation.

CONTRIBUTORY (Secondary) B. Id. Lymphomas (duration) yrs. mos. ds. Rt Inguinal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Cushman, M. D.

, 19 (Address) W. Balt. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pa

DATE OF BURIAL Aug 18 1930

UNDERTAKER Shenowethlon

ADDRESS 2615 Hunt

—1-30—M. & T.—250 Bks.

E 59840 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 E 59840

REGISTERED NO.

1-PLACE OF DEATH Sinai Hosp

CITY OF BALTIMORE: (No. 7-13 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Hecht

(a) RESIDENCE NO. Aged Home, Sinai Hosp WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Simon Hecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Hannah Lush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Sinai Hospital.

(Address)

Filed 7-1930 G. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930 to Aug 16, 1930, that I last saw him alive on 8-16-30, and that death occurred, on the date stated above, at 4 AM, 8 30

The CAUSE OF DEATH* was as follows: Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Course

(Signed) Milton B. Kursh M.D.

Aug 16 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Aug 17 1930

20 UNDERTAKER S. Ferneon Bro ADDRESS 127 E Balto St.

Spec.—1-10-21—M&T—1500 Bks.

E 59841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 59841

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1624 N. Smallwood St. (WARD) 15-68

2-FULL NAME Pinchos Kwall

(a) RESIDENCE NO. 1624 N. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Kwall

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 81 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Benj. Kwall

11 BIRTHPLACE OF FATHER (City or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Etta Ida --

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

PARENTS

14 Informant (Address): L. Lewis 1439 E. Baltimore St.

15 Filed 7 1930

C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1930, to Aug 15, 1930, that I last saw h alive on Aug. 15, 1930, and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Chron Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Oedema of Lungs (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. Baylin, M. D.

8/15, 1930 (Address) 2446 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cemetery

DATE OF BURIAL: 8-17-1930

20 UNDERTAKER: Jack Lewis, 1439 E Balto St.

ADDRESS

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59842

CERTIFICATE OF DEATH.

49 E 59842

REGISTERED NO.

1-PLACE OF DEATH St Josephs Hospital
TY OF BALTIMORE: (NO. Caroline Ave ST. 4-14 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Catherine M Kate Feehan

(a) RESIDENCE NO. 1744 E. Preston St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) May 14 1865

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	5	—	

CCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Patrick Feehan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Helen Claffey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Paul Feehan
(Address) 1744 E. Preston St

Filed 19 C. HAMPSON JONES, M. D. Registrar

71930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930 to Aug 14, 1930
that I last saw her alive on Aug 13, 1930
and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Pancreas

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hx unc
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? yes Date of 8/11/30
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Vincent Meaurs M. D.
, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery
DATE OF BURIAL 8 18 1930

20 UNDERTAKER Chas. P. Graul & Son
ADDRESS 1131 Mt Royal Ave

Cor.—10-10-29—A Co.—100 Bks.

59843

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓ E 59843

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospitals 16-23 Ward)

2-FULL NAME Otis Henry

(a) RESIDENCE NO. 904 N Carey St., Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27/08

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	21	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common 040
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph Henry

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mamie Hughlett

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Va

14 Informant Edna Anderson
(Address) 904 N Carey

15 Filed Aug 17 1930 C. HAMILTON JONES, M. D. Registrar
By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Pulmonary Tuberculosis
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Lymphoma Colli
(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? _____
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) James M Benbow M. D.
8 16 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Va	Aug 8 1930
20 UNDERTAKER	ADDRESS
Smith Chase Co	1405 Madison

c.—1-30—M. & T.—250 Bks

59844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 59844

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 423 N. Washington St. 4 WARD)

2-FULL NAME Susie Wisel

(a) RESIDENCE NO. 423 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (HUSBAND OF or) WIFE of John L. Wisel

DATE OF BIRTH (month, day, and year) Oct 12 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	10	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Nelson — —

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Louise — —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant John L. Wisel

(Address) 304 S. Highland Ave.

Filed 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 30

17 I HEREBY CERTIFY, That I attended deceased from July 1 1930 to Aug 14 1930

that I last saw her alive on Aug 13 1930

and that death occurred, on the date stated above, at 3 30 p.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward L. Cook M. D.

8/15 1930 (Address) 410 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Aug 18 1930

ADDRESS 2016 Eutaw St.

UNDERTAKER Philip Herwig

Cor.—10-10-29—A Co.—100 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 59845

REGISTERED NO. E 59845

1-PLACE OF DEATH

City of Baltimore: (No. Pier No, 8 Pratt St. St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Llewellyn Walter.

(a) RESIDENCE NO. 103 N. Milton Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of ~~WIFE of~~ Jennie Walter.

6 DATE OF BIRTH (month, day, and year) July 22, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	0	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rigger.
(b) General nature of industry, business, or establishment in which employed (or employer) M. & M. T. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Asa Walter.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Catherine ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Clarence Walter. (son)
(Address) 918 N. Collington Ave.

Filed AUG 7 1930. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.

8/15, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL Aug 18/30

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59846

59846

CERTIFICATE OF DEATH.

X 129

12-49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Memorial Hospital

TY OF BALTIMORE: (No. 33rd St Calvert ST. WARD)

2-FULL NAME Dr Wade H Brannon

(a) RESIDENCE NO. Anniston Ala ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Minnie V. Brannon

DATE OF BIRTH (month, day, and year) Dec 11 1888

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Medical Doctor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Birmingham Ala

10 NAME OF FATHER G H Brannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Mildred Sun Flem

13 BIRTHPLACE OF MOTHER (city or town) New Orleans (State or country)

Informant Wife - Northeast Reynolds

(Address)

Filed AUG 7 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17 1930

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1930, to August 17, 1930, that I last saw him alive on August 17, 1930, and that death occurred, on the date stated above, at 8 10 Day Light Time a. m.

The CAUSE OF DEATH* was as follows:

(a) Nephritis Chronic

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Anniston Ala.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William R. Fargo M. D.

Aug 7th 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Anniston, Ala.	Aug 17, 1930
UNDERTAKER	ADDRESS
John A Mitchell & Sons	1900 Eutaw St.

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

59847 179 V E 59847

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto Gen Hos ST. 25 WARD 32

2-FULL NAME Kenyon Wilton Rockenfuss

(a) RESIDENCE NO 2813 Maisel ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Child

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 3/26/27

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	4	11	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Geo P. Rockenfuss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ruth E. Hayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Geo P. Rockenfuss

(Address) 2813 Maisel St.

Filed ..... 192 C. HAMPSON JONES, M. D. Registrar

7 1930 By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto accident in which he was riding when
auto was filled with Gasoline when examined
with lighted lantern the gasoline exploded
Cause (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 3 degree burns of upper
extremities (duration) 1 hrs. 1 mos — Doctors
Report

18 Where was disease contracted if not at place of death? Gentlemans

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Frame Coroner, M. D.

1719 30 (Address) 3934 E. Eldeny

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Pauls Dickeyville

DATE OF BURIAL 8/18 1930

UNDERTAKER John. A. McMann

ADDRESS 3000 E. Balto St.

30—M. & T.—100 B—50L

E 59848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59848

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST., 7-9 WARD)

2-FULL NAME Nevel Dodson

(a) RESIDENCE NO ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 4/1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		8	13	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Thomas Dodson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Gail Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Thomas Dodson
(Address) Bethseda, Md.

Filed 8/17/30 192 C. HAMPSON JONES, M. D. Registrar

71930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dysentery (Class undetermined)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) ..... M. D.
Coroner

(Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Potomac Cem.

DATE OF BURIAL Aug 18 30

20 UNDERTAKER Warren Trumbley

ADDRESS Rockville

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 59849

CERTIFICATE OF DEATH

E 59849

X 74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. University Hospital St. 14-30 Ward)

2-FULL NAME Anna B. Needer

(a) RESIDENCE NO. York, Md St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Francis Needer.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Nursing Hospital Records
(Address)

15 Filed 19 Registrar

1 7 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

Aug 17. 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York M. E. Cem	Aug 19 30
20 UNDERTAKER	ADDRESS
Hornberger & Goss	York.

E. HAMILTON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59850

REGISTERED NO. E 59850

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

90-64 90

1-PLACE OF DEATH

City of Baltimore: (No. 2268 E. Baltimore St. St., Ward)

2-FULL NAME Catherine Staubitz.

(a) RESIDENCE NO. 2268 E. Baltimore St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow.

6a If married, widowed, ~~or divorced~~ (or) WIFE of John Staubitz.

6 DATE OF BIRTH (month, day, and year) October 12, 1849

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	80	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER George Petsch.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Sophie --------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Mrs. Anna Iebster. (daughter)
(Address) 2268 E. Baltimore St.

Filed 8 1930 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of The Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Eberhard, M. D.

8/15 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 18th 1930
20 UNDERTAKER	ADDRESS
F. O. Wippert	850 N. Baltimore St

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59851

CERTIFICATE OF DEATH.

E. 59851

118-001

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. University Hospital ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Hoffman

(a) RESIDENCE NO. 1906 Walbrook Ave ST. WARD

(Usual place of abode)

ength of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced HUSBAND of or) WIFE of Emma K. Hoffman

ATE OF BIRTH (month, day, and year) Feb 24 1855

GE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
75	5	21	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Emma K. Hoffman

(Address) 1906 Walbrook Ave

Filed 8 1930 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15, 1930

17

I HEREBY CERTIFY, That I attended deceased from 8/6/30, 19..., to 8/15/30, 19...,

that I last saw h.m alive on 8/15/30, 19...,

and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated 1d. Inguial Hernia

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? yes Date of 8/6/30

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) A. George H. Yeager M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Aug 19 19 30

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Chestnut Ave

c.—1-30—M. & T.—250 Bks.

E 59852 HEALTH DEPARTMENT—CITY OF BALTIMORE 34 E 59852

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. Sinai Hospital ST.. 7-13 WARD)

2-FULL NAME Charles Kittinger

(a) RESIDENCE NO. 1035 Dallas St ST.. WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of -

DATE OF BIRTH (month, day, and year) June 15-1903

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	2	-	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Charles A. Kittinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Catherine Gartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

Informant Catharine Kittinger
(Address) 1035 N. Dallas St

Filed 1-8 1930 C. HANSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/15/30

17
I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1930 to Aug 15, 1930,
that I last saw h in alive on August 15, 1930,
and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Psoas + Retroperitoneal abscesses (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of 8/14/30
Was there an autopsy? Yes
What test confirmed diagnosis? Aspiration Pus
(Signed) Irwin Koller M. D.
8/16, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem Hanover, Pa.
DATE OF BURIAL aug. 18 1930
UNDERTAKER George W. Zirkler
ADDRESS 1737 E. Eager st.

c. 2-29-28—L. F. S.—500 Bks.

E 59853 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 59853

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3405 Benson Ave. ST. 25-12 WARD)

2—FULL NAME John T. Farrell

(a) RESIDENCE NO. 3405 Benson Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Farrell

6 DATE OF BIRTH (month, day, and year): Oct. 16" 1870

7 AGE: Years 59 Months 10 Days xx If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N.S.

10 NAME OF FATHER: John Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wexford Ireland

12 MAIDEN NAME OF MOTHER: Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wexford Ireland

Informant: Mrs. John T. Farrell

(Address): 3405 Benson Ave.

Filed Aug 18 1930 C. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August, 16" 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-5 . 1930 , to 8-16 . 1930

that I last saw him alive on 8-16 . 1930

and that death occurred, on the date stated above, at 12.50 P.M.

The CAUSE OF DEATH* was as follows:

Maligancy of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Myocarditis.

Did an operation precede death? NO Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical findings.

(Signed) A. Neal Owens, M. D.

8/16/1930 (Address) Windsor Court Apartments.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: Aug. 19" 1930

20 UNDERTAKER: Joseph B. Cole

ADDRESS: 1003 West Baltimore St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59854

CERTIFICATE OF DEATH

E 59854

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals St.) (Ward)

2-FULL NAME Mahala J. Johnson

(a) RESIDENCE NO. 1019 W Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	widow

6a If married, widowed, or divorced
HUSBAND of (or) WIFE of the late Paul W Johnson

6 DATE OF BIRTH (month, day, and year) Nov 16th 1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	77	9	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

10 NAME OF FATHER Frederick Seybolt

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Francis Amelia Seybolt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs Mary E. Lashford (Address) 764 Oakwood Blvd. Chicago Ill.

15 Filed AUG 18 1930 C. HAMPSON JONES, Registrar

By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylaric End of Stomach

(duration) 2 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

1930 (Address) 702 E Chase St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	8/20/1930
20 UNDERTAKER John J Cowan & Son	ADDRESS 911 Holland St

Rec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59855

CERTIFICATE OF DEATH.

E 59855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1125 Argyle ST. 17-24 WARD)

2-FULL NAME Mary O. Wood

(a) RESIDENCE NO. 1125 Argyle ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Sept 1878

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, hrs or min.
51	11		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Geny C. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Alexander Wood (Address) 1125 Argyle Ave

Filed 8 1930, 19. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16/1930

17 I HEREBY CERTIFY, That I attended deceased from about, 1930. to Aug 16, 1930.

that I last saw h.. alive on Aug 16, 1930.

and that death occurred, on the date stated above, at 2:30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) about 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Jameson M. D.

8/18, 1930 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 8/18/1930

20 UNDERTAKER Mrs. George H. Holland

ADDRESS 1631 Druid Hill Ave

c.—2-29-28—L. F. S.—500 Bks.

E 59856

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59856

CERTIFICATE OF DEATH

161-600

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 1515 Lancaster ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME BABY RUSH

(a) RESIDENCE NO. 1515 Lancaster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

rth of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
le	White	Single

f married, widowed, or divorced
HUSBAND of
(or) WIFE of - - -

ATE OF BIRTH (month, day, and year) August 15, 1930

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) Baltimore
State or country)

0 NAME OF FATHER Henry C. Rush

1 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

2 MAIDEN NAME OF MOTHER Anne B. Rode

3 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

Informant Mr. Henry Rush (Father)

(Address) 1515 Lancaster Ave.

Filed AUG 18 1930

C. HARRISON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 16 1930, to ~~August 16~~ August 16 1930

that I last saw h~~im~~ alive on August 16, 1930

and that death occurred, on the date stated above, at 3.00 ~~p~~ a. m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) [illegible] M. D.

. 19 (Address) 1623 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lat. Evangelical Cemetery

UNDERTAKER Harry Sander & Sons, Inc.

DATE OF BURIAL Aug. 18, 1930

ADDRESS Baltimore St & Broadway.

c.—1-30—M. & T.—250 Bks

59857 HEALTH DEPARTMENT—CITY OF BALTIMORE 114 E 59857

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Mercy Hospital ST. 15-67 WARD)

2-FULL NAME Mrs. S. Dewitt Chapeman

(a) RESIDENCE No. 3210 Wallbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Grace ?B. 1873

ATE OF BIRTH (month, day, and year) Oct. 7, 1884

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56 yrs.	10	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Canton Ohio

10 NAME OF FATHER Chester Chapman

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Md. or Pa.

12 MAIDEN NAME OF MOTHER Emma ?Anderson

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Pa

rmant Hospital Friends.

ress)

R. HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15/30

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1930, to August 15, 1930, that I last saw him alive on August 15, 1930, and that death occurred, on the date stated above, at 6 40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis.

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary) Acute Shock - Unnamed.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) G. Burns Manchester M. D.

8/15, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Pk. Mausoleum

DATE OF BURIAL 8/18 1930

20 UNDERTAKER Harry A. Pentz

ADDRESS 4708 Edmondson Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59858

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 59858

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave St. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Burns

(a) RESIDENCE No. 327 S. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 22, 1916

7 AGE: Years 13 Months 10 Days 25 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Lawrence W. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Grissie Buckmaster

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Laurence Burns (Address) 327 S Stricker St

15 Filed 8/18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16 1930

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1930, to Aug. 16, 1930, that I last saw he alive on Aug 16, 1930, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho. pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of July 30, 1930

Was there an autopsy?

What test confirmed diagnosis?

8/16/30. (Signed) Robert Leaver, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk. | DATE OF BURIAL 8/ /19 30

20 UNDERTAKER Harry N. Wright | ADDRESS 410 Edmondson

30—M. & T.—100 B—50L

E 59859

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59859

CERTIFICATE OF DEATH

REGISTERED NO. 202

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp (St.) 8-17-30 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Clarence Winter

(a) RESIDENCE NO. 3902 Mortimer Av (St.) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Grace

DATE OF BIRTH (month, day, and year) Mar 1899

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	5		

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Pa.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Mrs

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant: Grace Winter

(Address): 3902 Mortimer Av

Filed 8-19-30 192 C. HAMBLETON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Aug 15th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Fractured Skull and Ribs (duration) yrs. 2 mos. 2 days

CONTRIBUTORY (Secondary) Freefell from body of Saddle (duration) yrs.

18 Where was disease contracted if not at place of death? Mortimer Av

Did an operation precede death? No. Date of

Was there an autopsy? yes

What test confirmed diagnosis? Regular

(Signed) M. Klein, M. D. Coroner

Aug 17 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National — DATE OF BURIAL: 8/19 1930

20 UNDERTAKER: Harry A Ritzke — ADDRESS: 410 Edmondson

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59860

E 59860

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland University Hospital

TY OF BALTIMORE: (No. 11-74 ST. WARD)

2-FULL NAME Baby Boy Drechsler

(a) RESIDENCE NO. Edgewood Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	W.	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Aug 7, 1930

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			21	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Edgewood Md
(State or country)

10 NAME OF FATHER George A. Drechsler

11 BIRTHPLACE OF FATHER (city or town) Carroll Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Bernial Fair

13 BIRTHPLACE OF MOTHER (city or town) Pikesbury Park.
(State or country)

Informant Lewis A. Drechsler
(Address) Carollton Md.

Filed 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18, 1930

17

I HEREBY CERTIFY, That I attended deceased from August 14, 1930, to Aug 18, 1930,

that I last saw him alive on Aug 18, 1930,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Prematurity, malnutrition

3 wks (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At birth

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Weight page

(Signed) C. E. Sanderson, M. D.

, 19 (Address) University of Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Chas. Lustiss Church

DATE OF BURIAL Aug. 19 193

20 UNDERTAKER Lewis A. Drechsler

ADDRESS Carollton Md

ec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59861

CERTIFICATE OF DEATH

31 E 59861

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. U.S. Marine Hospital ST., 67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emile J. Brauer

(a) RESIDENCE NO. 3013 Baker St., Walbrook, Baltimore, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Aug. 17, 1905

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	11	29	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Radio Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

IRTHPLACE (city or town) Baltimore
State or country) Md.

10 NAME OF FATHER Charles Brauer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Zerbin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

Informant Hospital Records

(Address) U. S. Marine Hospital

Filed AUG 18 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16, 1930

17

I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to Aug 16, 1930,

that I last saw h. alive on Aug. 16, 1930

and that death occurred, on the date stated above, at 4 4. m. S.T.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary for Bar Advanced.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory

(Signed) Gordon A. Abbott M. D.

, 19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 8/19/30 19

20 UNDERTAKER H. C. Brauer & Son.

ADDRESS 136 Poplar Grove St.

c.—1-30—M. & T.—250 Bks.

9862

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 59862

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. 3722 Manchester Ave 27-56 WARD)

2-FULL NAME Annie B Horan

(a) RESIDENCE NO. 3722 Manchester Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) April 26 1867

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	3	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Sykesville Md

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Faudenbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Marion F Horan

(Address) 3722 Manchester Ave

8 1930 . 19 H. [illegible] JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to August 16th, 1930, that I last saw her alive on August 6th, 1930, and that death occurred, on the date stated above, at 3, 54 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene of Foot

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Sollenberger M. D.

16, 1930 (Address) 1211 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug 18 1930
20 UNDERTAKER	ADDRESS
J Vernon Kellner	Hollins

c.—2-29-28—L. F. S.—500 Bks.

59863 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59863

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Fayette & Calhoun ST. 27-56 WARD)

2—FULL NAME Mrs. Edna Wright

(a) RESIDENCE NO. 4926 Palmer Ave ST., WARD
(If non-resident give city or town and State)

gth of residence in city or town where death occurred 39 yrs. 10 mos. 20 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Widow

f married, widowed, or divorced
HUSBAND of (or) WIFE of William J. Wright

ATE OF BIRTH (month, day, and year) Sept. 27, 1890

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	10	20	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer L. Grief & Co.

IRTHPLACE (city or town) Baltimore
State or country) Maryland

0 NAME OF FATHER George T. Williams

1 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

2 MAIDEN NAME OF MOTHER Lucretia Wamsley

3 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Mrs. Geo. T. Williams
(Address) 4926 Palmer Avenue

Filed AUG 18 1930 C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-17-30

17 I HEREBY CERTIFY, That I attended deceased from 8-9-, 1930, to 8-17-, 1930, that I last saw her alive on 8-17- 1930 and that death occurred, on the date stated above, at 8 05 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Hypertension (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination on ground

(Signed) M. B. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 8/20 19 30

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 W. Calvert

c. 12-29-28—L. F. S.—500 Bks.

59864

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 59864

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Apartments ST., 21 WARD)

2—FULL NAME John I French

(a) RESIDENCE NO. University Apartments ST.

WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret H. O'Neill

DATE OF BIRTH (month, day, and year) -------

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	--	--	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Townsend Grace Baltimore

BIRTHPLACE (city or town) (State or country) Maryland

NAME OF FATHER William H. French

BIRTHPLACE OF FATHER (city or town) (State or country) Not obtainable

MAIDEN NAME OF MOTHER Sarah Livingston

BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mrs. Margaret H. French

(Address) 106 W. University Parkway

Filed AUG 8 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16-30

17 I HEREBY CERTIFY, That I attended deceased from March 10 . 1928 . to Aug 16 . 1930.

that I last saw h[illegible] alive on aug 16 . 1930

and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) R. L. Ruffin M. D.

. 19 (Address) Wentworth Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 8/19 19 30

20 UNDERTAKER Henry H. Deaver Son

ADDRESS 605 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

E 59865

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59865

REGISTERED NO. 197

25-32

1-PLACE OF DEATH

City of Baltimore: (No. 2231 Annapolis Ave Westport St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Bartscher.

(a) RESIDENCE NO. 2231 Annapolis Ave St., Westport Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of John F. Bartscher

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Missouri.
(State or country)

PARENTS

10 NAME OF FATHER J. E. Sackett.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Louis Bartscher.
(Address) 2231 Annapolis Ave.

15 Filed AUG 18 1930 WILLIAM H. JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration of the brain due to a pistol wound of the head inflicted by her husband John F. Bartscher who committed suicide.. Homicide. (duration) ---- yrs. ---- mos. ---- ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt M. D.

8/18, 1930 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Aug 18 1930
20 UNDERTAKER Jesse Lyles	ADDRESS York Nebr

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59866 ✓ 170 E 59866

REGISTERED NO. 25-37

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2231 Annapolis Ave Westport Ward)

2-FULL NAME John F. Bertscher.

(a) RESIDENCE NO. 2231 Annapolis Ave Westport. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Hattie Bertscher.

6 DATE OF BIRTH (month, day, and year) June 4, 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	38	2	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER August Bertscher.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Ida Kramer.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Co. Md.

14 Informant Louis Bertscher. (cousin)
(Address) 2231 Annapolis Ave.

Filed ... 19... HAMPSON JONES, M. D.
Registrar

8 1930 C. H. M. D.

War

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration of the brain due to a pistol wound of the head self inflicted after having shot his wife Hattie.

Suicide. (duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas. H. Leonard, M. D.

8/18, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Aug 18 19
20 UNDERTAKER Josiah Syfer	ADDRESS [illegible]

C.—1-30—M. & T.—250 Bks.

2395 75
E 59867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59867

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (STREET AND NUMBER) 24-35 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.

2-FULL NAME Jacqueline Ripfretoe

(a) RESIDENCE NO. 1400 E Fort ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) July-15-1930

GE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	1	1	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Ripfretoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Evelyn Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

Informant (Address) Johns Hopkins Hosp'l. Records

Filed 1-8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-16-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 16, 1930, that I last saw her alive on Aug 16, 1930, and that death occurred, on the date stated above, at 10 10 P m.

The CAUSE OF DEATH* was as follows:

Meningitis Influenza

(duration) yrs. mos 28 ds.

CONTRIBUTORY (Secondary) Cerebral Birth Hemmorrhage (duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Cistern Puncture

(Signed) J. C. Jacobs, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Aug 18 1930
UNDERTAKER Margaret S. Flynn	ADDRESS 1411 Light St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59868 E 59868

CERTIFICATE OF DEATH.

REGISTERED NO. 172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2001 Barclay St. (ST.) 12-19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel E. Owens.

(a) RESIDENCE NO. 2001 Barclay St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Owens.

7 DATE OF BIRTH (month, day, and year): August 17th. 1884

AGE: Years 46 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: James Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Neville

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

Informant: Mrs Alfred Buckley

(Address): 2233 Guilford Ave.

AUG 18 1930 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and ye): August 16th. 30.

17 I HEREBY CERTIFY, That I attended deceased from August 15 1930. to Aug 16 1930.

that I last saw h living on Aug 16 1930.

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis
Chronic nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Heart Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tovey, M. D.

8-17 1930 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 8/19 1930

20 UNDERTAKER: Chas. G. Krause Son 1107 N. Royal Ave

ADDRESS

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59869

CERTIFICATE OF DEATH.

161-001 E 59869

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Mercy Hospital ST. 20-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Stivins

(a) RESIDENCE NO. Mercy Hospital ST., 426 Fitzhugh Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				30 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Mercy Hospital Balto Md

10 NAME OF FATHER Walter Stivins

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Marie Young

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Baltimore Md

Informant Hospital Records

(Address)

Died Aug 16 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1930, to Aug 16, 1930, that I last saw h e alive on Aug 16, 1930, and that death occurred, on the date stated above, at 6 7 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental hemorrhage on part of mother (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. Bruce Wagenhorst M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL AUG 18 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59870

15 E 59870

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH: (a) CITY OF BALTIMORE: (No.) Hospital Hospital ST., WARD) Caroline & Orleans 817

2-FULL NAME Baby Girl Meade

(a) RESIDENCE NO. 1418 N Broadway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Wh	Infant

If married, widowed, or divorced: HUSBAND of or) WIFE of Infant

DATE OF BIRTH (month, day, and year) 8-12-30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bowie Md

10 NAME OF FATHER John Meade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salisbury N. C.

12 MAIDEN NAME OF MOTHER Helen Medaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

Informant (Address) Hospital

Filed AUG 18 1930 C. H. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-30

17 I HEREBY CERTIFY, That I attended deceased from 8-12-30, 19..., to 8-16-30, 19..., that I last saw h[illegible] alive on 8-16-30, 19..., and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: AUG 18 1930, 19

20 UNDERTAKER [illegible] Director of Health

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-103

E 59871

CERTIFICATE OF DEATH

E 59871

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1407 Maryland Ave) (Ward 10-14)

2-FULL NAME Celia Cohen

(a) RESIDENCE NO. 1404 E Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Louis Cohen

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis 1431 E Biddle St.

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

R 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows: Auto in which she was riding ~~caused~~ was struck by another Auto which passed

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneu

(Duration) yrs. mos. ds.

18 Where was disease contracted? if not at place of death? Home 866 Portland to Hosp.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Braun M. D.

8/18, 1930 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Hebrew Cem	8-18- 1930
20 UNDERTAKER	ADDRESS
Jack Davis	1431 E Biddle

30—M. & T.—100 B—50L

E 59872

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59872

CERTIFICATE OF DEATH

6-9 + 185

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary St. (WARD) 6-9

2-FULL NAME Sophie Earecksson

(a) RESIDENCE No. 22 nd. Ave., Annapolis, Md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Feale	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Roderick W. Earickson

DATE OF BIRTH (month, day, and year) Feb 27/1843

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	5	20	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Talbott Co.

10 NAME OF FATHER William Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co.

12 MAIDEN NAME OF MOTHER Sarah E. Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

Informant Mrs. Mary E. Nester

(Address) Lykens, Pa.

8 1930 — C. HAMPSON JONES, M. D., Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bilateral Apoplexy

(Accidently slipped on rug inher home)

(duration) yrs. mos 1 hr. ds.

CONTRIBUTORY (Secondary) Frac. Left neck Femur

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? Reduction f fracture Date of Aug 8/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..... Coroner, M. D.

8/18/30 (Address) 508 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkridge Md.

DATE OF BURIAL 8/17/30

20 UNDERTAKER Henry M. Jenkins

ADDRESS Baltimore Cathedral St

c.—1-30—M. & T.—250 Bks.

59873 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59873

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 4640 Park Height ST. 27-56 (WARD)

2-FULL NAME Rev William L Russell

(a) RESIDENCE NO. 4640 Park Height ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

f married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) July 14, 1886

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	1	6	2

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister Gospel

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER Major Myron Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Edith Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ny

Informant Mary E Russell

(Address) 4640 Park Height

Filed AUG 8-1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16. 1930

17 I HEREBY CERTIFY, That I attended deceased from September, 1929 to August 16, 1930, that I last saw him alive on August 15, 1930, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cardiac degeneration.

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) C. W. Hoffman, M. D.

, 19 (Address) 8 East Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Aug 19 1930

20 UNDERTAKER George J Smith

ADDRESS 153 Holden

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59874

CERTIFICATE OF DEATH.

161

E 59874

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 11-24 WARD)

2-FULL NAME Baby Boy Drummond

(a) RESIDENCE NO. 1031 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 13, 1930

AGE: Years | Months | Days | If LESS than 1 day, 3 hrs. & 15 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

10 NAME OF FATHER Thomas Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Savannah Drummond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Savannah Drummond (Address) 1031 Druid Hill Ave JOHNS

15 AUG 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1930, to Aug 13, 1930, that I last saw him alive on Aug 13, 1930, and that death occurred, on the date stated above, at 3:50 p m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

Prematurity (32 WKS)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? Clinical observation

What test confirmed diagnosis?

(Signed) Louis H. Degraaf M. D.

8/15 1930 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: 18 1930

20 UNDERTAKER

ADDRESS

Commissioner Health

War. Wm. H. McGee

Dr Mayer 2438 Eutaw Place

c.—1-30—M. & T.—250 Bks.

E 59875 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59875

CERTIFICATE OF DEATH. 129

REGISTERED NO. 27-43

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 7215 Harford Ave St., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara W. Graves

(a) RESIDENCE NO. 7215 Harford Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, ~~or divorced~~ (HUSBAND) of or) WIFE of William W.

ATE OF BIRTH (month, day, and year) Aug 21st 1859

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	11	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

IRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Isaac H. Mathews

(Address) 7215 Harford Rd

Filed 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17-1930

17 I HEREBY CERTIFY, That I attended deceased from January, 1929, to August 17, 1930, that I last saw her alive on August 17, 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Brights disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O. W. H. A. Mayer, M. D.

Aug. 7 1930 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 8/20/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

c.—1-12-23—M&T—500 Blks.

E 59876

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Lanfons Memorial Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 1000 Caton Ave ST. 25-22 WARD

2-FULL NAME John Trigar Moore

(a) RESIDENCE NO. Cherry Hill Farm ST. Catonsville Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) July 12th 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	1	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Agriculture

(c) Name of employer Self

IRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER James Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Esther Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Lanfons Memorial Hosp

(Address) 1000 Caton Ave

G. HAMPSON JONES, M. D.

Registrar

1930

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug. 17, 1930, that I last saw [redacted]alive on Aug 17, 1930, and that death occurred, on the date stated above, at 1506 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Accident

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hjalmar S Anderson M. D.

, 19 (Address) 51 Agnes Hafield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 8/20 1930

20 UNDERTAKER J M Cole

ADDRESS 1217 N Fulton

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59877

CERTIFICATE OF DEATH.

E 59877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2305 Eutaw Place ST.) 43-59 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Carey Lewis

(a) RESIDENCE NO. 2303 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert B. Lewis

6 DATE OF BIRTH (month, day, and year): Dec 4, 1858

7 AGE — Years: 71 — Months: 8 — Days: 13 20 — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Francis Kirk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Lewin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): (Sister) Mrs. A. M. McCann 2303 Eutaw Place

15 Filed 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Aug 17, 1930, that I last saw her alive on Aug 17, 1930, and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Frank Levinson, M. D.

19 (Address) 2305 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 8/20 1930

20 UNDERTAKER: Fulton Cook

ADDRESS: 1217 Eutaw

130 M. & T. 250 Bks.

E 59878

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59878

CERTIFICATE OF DEATH.

129

REGISTERED NO. 19-28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1520 Ramsay St. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Akers

(a) RESIDENCE NO. 1520 Ramsay St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Allena H. Akers (nee Hipsley)

7 DATE OF BIRTH (month, day, and year) Sept. 3, 1865.

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	11	15	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper 019

(b) General nature of Industry, business, or establishment in which employed (or employer) Confectionery

(c) Name of employer Self

10 BIRTHPLACE (city or town) (State or country) Md.

11 NAME OF FATHER Edwin Akers

12 BIRTHPLACE OF FATHER (city or town) (State or country) England

13 MAIDEN NAME OF MOTHER Caroline Pasey

14 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Sadie L. Akers

(Address) Westminster, Md.

Filed AUG 8 1930 19 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18/30

17 I HEREBY CERTIFY, That I attended deceased from 7/1/, 19 30, to 8/18/, 19 30,

that I last saw h— alive on 8/18, 19 30,

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Chronic Nephritis

(duration) — yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard Lang, M. D.

8/19 1930 (Address) 410 Belmont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 8/20/30

UNDERTAKER Harry V. Lutz

ADDRESS 4101 Edmondson Ave.

30—M. & T.—100 B—50L

E 59879

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 E 59879

REGISTERED NO. 15-63

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Sarah Frank

(a) RESIDENCE NO 3817 Barrington Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Frank

DATE OF BIRTH (month, day, and year) Aug 30/1857

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	11	18	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md

10 NAME OF FATHER Wm. Eilan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Bitter

13 BIRTHPLACE OF MOTHER (State or country) ~~Germany~~

Informant Isaac Frank

(Address) 3817 Barrington Road

Filed ... 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Coronary Thrombosis

(duration) yrs. mos 7 ds

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) ... M. D. Coroner

8/18/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Heren — DATE OF BURIAL Aug 20 1930

20 UNDERTAKER Harr Sondheim & Son — ADDRESS 1902 Eutaw

2-29-28—L. F. S.—500 Blks.

E 59880 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59880

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1614 Baker ST. 15-21 WARD)

2—FULL NAME Caroline C. Milburne

(a) RESIDENCE NO. 1614 W. Baker ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of: Samuel Milburne

6 DATE OF BIRTH (month, day, and year): April 4/1871

AGE: Years 59 | Months 4 | Days 13 | If LESS than 1 day, hrs. or min.

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

8 BIRTHPLACE (city or town) (State or country): Howard Co. Maryland

9 NAME OF FATHER: Patrick Addison

10 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co. Maryland

11 MAIDEN NAME OF MOTHER: Caroline Fuller

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Maryland

Informant: Mrs Effie Berry
(Address) 1633 Westwood Ave

Filed AUG 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-17-30

17:

I HEREBY CERTIFY, That I attended deceased from April 17 . 1930. to August 17 . 1930.

that I last saw her alive on August 16 . 1930

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Nephritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) John E. L. Campbell M. D.

. 19 (Address) 1724 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Aug 19th 1930

20 UNDERTAKER: Thomas E Kelson — ADDRESS: 808 Dreshman St

M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59881

E 59881

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) Md Gen Hosp ST. 11-24 WARD)

2-FULL NAME Vincent de Leo

(a) RESIDENCE NO 1311 - 17th St Phila Pa WARD .....

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) Nov 1899

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	0		

CUPATION OF DECEASED
) Trade, profession or rticular kind of work Electrician
) General nature of industry, siness, or establishment in hich employed (or employer)
) Name of employer

THPLACE (city or town) Phila Pa
ate or country)

NAME OF FATHER Eugenio de Leo

BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

MAIDEN NAME OF MOTHER Concetta de Berardino

BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

rmant Vincent de Berardino

Address) 125 S. Clinton St.

C. HAMPSON JONES, Registrar

E 1 8 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Due to wound inflicted by struck pillar by Fordyce

(Duration) Rupture (a) Fuel or Drum Yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Owings Mill

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Frauer M. D.
Coroner

19 (Address) 1039 Md Ridge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

DATE OF BURIAL 8/18 1930

UNDERTAKER Edw. N. Zuckermaker

ADDRESS 637 S. Broad St

c.—1-30—M. & T.—250 Bks

E 59882

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

90 E 59882

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE; (No. 1149 N. Hamburg ST. 21-44 WARD)

2-FULL NAME Elizabeth Gallauer

(a) RESIDENCE NO. 1149 N. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Gallauer

ATE OF BIRTH (month, day, and year) July 11. 1848

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	1	6.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Switzerland

10 NAME OF FATHER Strassler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Albert Gallauer

(Address) 1149 N. Hamburg St.

9-1930 G. HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17/30.

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to August 17, 1930.

that I last saw h.er alive on August 17, 1930.

and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 1/2 mos da.

Pleurisy. —

CONTRIBUTORY (Secondary) (duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? no. —

What test confirmed diagnosis? none

(Signed) Harry Gates, M. D.

, 19 (Address) 573 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern Cem. DATE OF BURIAL Aug 20, 1930.

20 UNDERTAKER Mr. Mrs. John W. Tenfel & Son ADDRESS 801 W. Fayette

c.—2-29-28—L. F. S.—500 Bks.

Mrs Gurley

HEALTH DEPARTMENT—CITY OF BALTIMORE

59883

CERTIFICATE OF DEATH

161-001 E 59883

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Fountain Ave ST. 29 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant of Mrs Mildred Mae Gurley

(a) RESIDENCE NO. 2500 Fountain Ave ST., WARD (If non-resident give city or town and State)

(Usual place of abode) How long in U. S., if foreign birth? yrs. mos. ds.

Length of residence in city or town where death occurred yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

7 DATE OF BIRTH (month, day, and year) Aug. 15 1930.

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1 day	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.. none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) Baltimore
(State or country)

11 NAME OF FATHER unknown

12 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

13 MAIDEN NAME OF MOTHER Mildred Mae Gurley

14 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

Informant John F. Gurley

(Address) 2500 Fountain Ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Aug 18, 1930, that I last saw h[illegible] alive on Aug 18, 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature birth.
Seemed about 6 or 7 month.
Could not feed it.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

(Address) 4708 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL Aug 19 1930

20 UNDERTAKER Mrs Mrs John W. Teufel & Son — ADDRESS 801 W. Fayette

c.—1-30—M. & T.—250 Bks.

E 59884

59884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. University Hospital 4-30 ST., WARD)

2-FULL NAME Frank J. Schmidt.

(a) RESIDENCE NO. 127 N. Paca St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Frieda Schmidt

ATE OF BIRTH (month, day, and year) apr 24. 1879

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	25	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor

(c) Name of employer

IRTHPLACE (city or town) (State or country) Austria

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Frieda Schmidt

(Address) 127 N. Pine St

C. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18/30 -

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1930, to Aug 18, 1930, that I last saw h alive on Aug 18, 1930, and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows:

Compound fracture of The Rt. femur -

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Delirium Tremens -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? no -

Did an operation precede death? no Date of -

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) George H. Yeager - M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug 20, 1930.

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son

ADDRESS 801 W. Fayette

8-1930

C—1-30—M. & T.—250 Bks.

59885 HEALTH DEPARTMENT—CITY OF BALTIMORE 117 E 59885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 18-76 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ..... WARD)

2-FULL NAME Thomas Brown

(a) RESIDENCE NO. 809 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	married

married, widowed, or divorced HUSBAND of (or) WIFE of Viola Brown.

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
2		—	—	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture store

(c) Name of employer Hecht Brothers.

IRTHPLACE (city or town) (State or country) N.C.

0 NAME OF FATHER Thomas Brown

1 BIRTHPLACE OF FATHER (city or town) ? (State or country) N.C.

2 MAIDEN NAME OF MOTHER Mary Anna ?

3 BIRTHPLACE OF MOTHER (city or town) ? (State or country) N.C.

Informant Friends (Address) Baltimore City

Filed 1-9 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-17-30

17 I HEREBY CERTIFY, That I attended deceased from 6-17-1930, to 8-17, 1930, that I last saw him alive on 8-17, 1930, and that death occurred, on the date stated above, at 2 12 / 4 m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix

Generalized ~~fecal~~ peritonitis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 6-21-30

Was there an autopsy? no

What test confirmed diagnosis? operation.

(Signed) Fred M. Dunkwell, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington, N. C.

DATE OF BURIAL Aug 19, 1930

UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 Schroeder St.

c—1-30—M. & T.—250 Bks.

E 59886

59886

HEALTH DEPARTMENT—CITY OF BALTIMORE

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospital

TY OF BALTIMORE: (NO. 21-31 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gantt

(a) RESIDENCE NO. 929 S China St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	colored	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of James Gantt

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	7	2	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

IRTHPLACE (city or town) (State or country) Annapolis Md.

0 NAME OF FATHER Anthony Williams

1 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

2 MAIDEN NAME OF MOTHER Eunice Wallace ?

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Rundle Baltimore City Hosp.

(Address)

Filed 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-30

17 I HEREBY CERTIFY, That I attended deceased from 5-31-, 1930, to 8-16, 1930, that I last saw h alive on 8-16, 1930, and that death occurred, on the date stated above, at 9 4/4 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of body of uterus with local metastases

(duration) unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) Fred M. Dunbar, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 20, 1930
20 UNDERTAKER Mrs. Kate R. Williams	ADDRESS 322 N. Schroeder St

—2-29-28—L. F. S.—500 Bks.

59887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 C E 59887

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 Vine ST. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Solomon N. Bowie

(a) RESIDENCE NO. 720 Vine ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jany 16 10

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Tire repair

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Jno. Bowie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Maria Leanord

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Maria Carroll Bowie

(Address) 723 Vine St.

Filed Aug 19 1930 J. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15/30

17 I HEREBY CERTIFY, That I attended deceased from July 9 1930, to Aug 15 1930

that I last saw him alive on Aug 15 1930

and that death occurred, on the date stated above, at 11.45 P.M. (S.T.)

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank E. Wagner M. D.

Aug 16, 1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug 19, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N Schroeder St.

20—M. & T.—100 B—50L

E 59888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 133 E 59888

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp (Street) 12-20 (WARD)

2-FULL NAME Joseph Wood.

(a) RESIDENCE NO 15 W. La Fayette St. WARD 8th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Single.

DATE OF BIRTH (month, day, and year): 1898-

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Campbell S. C.

10 NAME OF FATHER: Duncan Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Martha Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

Informant: John Montgomery

(Address): 15 W La Fayette St.

FILED AUG 1930 M2 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Autopsy thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Ruptured Bladder

(duration) yrs. few days

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) H. H. Hebbeler, M. D. Coroner

(Address) Aug 16

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Camden S. C.

DATE OF BURIAL: Aug 19, 1930

20 UNDERTAKER: Mrs. Rik. Elliott

ADDRESS: 17 E Camden ave

c—1-30—M. & T.—250 Blks

59889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59889

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2214 Ruskin ave ST. 13-59 WARD

2-FULL NAME Anna Marie Zemmet

(a) RESIDENCE NO 2214 Ruskin ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs 6 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Harry Zemmet

DATE OF BIRTH (month, day, and year) Feb 8 1871

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59	6	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John Kasper Lehner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant John Harry Zemmet
(Address) 2214 Ruskin ave

Filed ..... C. HARRISON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11th, 1930, to Aug. 17th, 1930, that I last saw her alive on Aug. 17th, 1930, and that death occurred, on the date stated above, at 1125 P. m. Standard

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Probably

What test confirmed diagnosis?

(Signed) Cecil C. Kelly M. D.

8/18, 1930 (Address) 2221 W. Fayette St. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 8/20/1930

20 UNDERTAKER Jos. Nelson & Son

ADDRESS 2503 Edmondson

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 59890

REGISTERED NO. E 59890

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 3015 Brendan Ave ST., 26-40 WARD)

2-FULL NAME Carrie Lease

(a) RESIDENCE NO. 3015 Brendan Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	under White	Married

f married, widowed, or divorced (HUSBAND of or) WIFE of William Lease

ATE OF BIRTH (month, day, and year) June 5th 1859

AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
71	2	12	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) New York

10 NAME OF FATHER William White

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Ellen Champneys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Eva Kunibelson

(Address) 3015 Brendan Ave.

9-1930 ... 19 ... THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1930, to Aug 17, 1930, that I last saw her alive on Aug 17, 1930, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix & Glands.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) Sidney H. Stuart M. D.

8-18, 1930 (Address) 450 E Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Aug 20 1930

20 UNDERTAKER John Merrick

ADDRESS 2008 Orleans

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59891

CERTIFICATE OF DEATH

174 E 59891

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH John E. Hands

City of Baltimore: (No. Balt City Hos St. 8-17 Ward)

2-FULL NAME John E Hands

(a) RESIDENCE NO. 1619 Rutland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edna G. ~~Hands~~ Williams

6 DATE OF BIRTH (month, day, and year) Jan 17 1884

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
46	7	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Steam R. R. Co
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) West Virginia

10 NAME OF FATHER Wm H Hands

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto City

12 MAIDEN NAME OF MOTHER Sarah Cole

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Edna G Hands
(Address) 1619 Rutland Ave

C. HARPSON JONES, M. D.

15 Filed 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Catrophic Hepatitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

8 18 1930 (Address) 701 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 20 1930
20 UNDERTAKER	ADDRESS
Jos J Stevenson	5 E Fayette

Spec.—1-12-23—M&T—500 Blks.

E 59892

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59892

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3125 Mirimo Ave (ST.) (WARD) 8-40

2-FULL NAME Margaret Snyder

(a) RESIDENCE NO. 3125 Mirimo Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs 5 mos ds. How long in U. S., if of foreign birth yrs mos ds

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

4 COLOR OR RACE W

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word) Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Snyder

7 DATE OF BIRTH (month, day, and year) Feb 1 1876

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	74	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Andrew Emmine

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Gertrude Snyder (Address) 3125 Mirimo Ave

15 Filed AUG 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Aug 17, 1930, that I last saw her alive on Aug 16, 1930 and that death occurred, on the date stated above, at 6:30 a m

The CAUSE OF DEATH* was as follows:

Dyspnea, Interstitial Nephritis, Cardio Renal Disease

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis (duration) yrs several mos. ds.

Myocardial Insufficiency

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Chemical

(Signed) R. O. Carman, M. D.

8.18.1930 (Address) 1701 N Carlin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem - Aug 20 - 1930

DATE OF BURIAL

20 UNDERTAKER Jno J Stenston

ADDRESS 154 Laynore

10—M & T—100 B—501.

E 59893

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59893

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1034 N.Chapel ST. 7-13 (WARD)

2-FULL NAME Frank Valis

(a) RESIDENCE NO 1034 N. Chapel St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Filomena Valis

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Austria

10 NAME OF FATHER John Valis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Anna Dedouk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

Informant Frank Cvach

(Address) 1900 Ashland Ave

Filed AUG 19 1930

C 19 1930 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholism?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

8/18/30 (Address) 508 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Aug. 20 19 30

20 UNDERTAKER Frank Cvach & Son 1906

ADDRESS Ashland Av

30—M. & T.—100 B—50L

E 59894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 59894

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Harforf ave & Lanvale St. 9-18 WARD)

2-FULL NAME John. J. Seeger

(a) RESIDENCE NO 1642 Aisquith St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 mos. ds. How long in U. S., if of foreign birth? [illegible] yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Mollie. B. Seeger

DATE OF BIRTH (month, day, and year) March 9 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5		

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Jacob Seeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

Informant Mrs. Mollie. B. Seeger

(Address) No. 1642 Aisquith St.

Filed AUG 19 1930 Registrar C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) [signature] Coroner, M. D.

8/17/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Aug 20 1930

20 UNDERTAKER Henry Steck Sons Inc. — ADDRESS 1301 E Eager St

—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59895

CERTIFICATE OF DEATH.

88 E 59895

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 863 Linden Ave (St.) 24 (WARD)

2-FULL NAME John Pride

(a) RESIDENCE NO. 863 Linden Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Married

married, widowed, or divorced HUSBAND of or) WIFE of Ella Pride

ATE OF BIRTH (month, day, and year) Oct. 1880

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49.	10		

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) S. C.

0 NAME OF FATHER John Pride

1 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

2 MAIDEN NAME OF MOTHER Daye

3 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

Informant Ella Pride

(Address) 1609 Edmondson Ave

I[illegible] 9 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17/30

17 I HEREBY CERTIFY, That I attended deceased from 7/25, 1930, to 8/17, 1930

that I last saw h[illegible]ive on 8/17/30 19 4 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Acute Pericarditis 2nd

Acute Endocarditis

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Overwork

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Signs and Symptoms

What test confirmed diagnosis?

(Signed) J. R. Blake M. D.

8/19, 1930 (Address) 924 Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hill S.C.	Aug 19 30
20 UNDERTAKER	ADDRESS
Samuel Stansbury	Ft Dale

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9896 ✓ 3 | E 59896

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (NO. 516 W. West ST. 21-31 WARD)

2-FULL NAME Sarah Bornstein

(a) RESIDENCE NO. 516 W. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Hyman Bornstein

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Abr Bamberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Earl —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address) Louis 1439 E Balto St

Filed 8-20 19 30 C. H. P. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19/30

17 I HEREBY CERTIFY, That I attended deceased from 8/14/30, 19 30, to 8/19/30, 19 ....,

that I last saw h.. alive on 8/16/30, 19 ....,

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) asphyxia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8/19, 19 30 (Address) 836 Dulaney Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Sinai Cem

DATE OF BURIAL 8-19- 19 30

20 UNDERTAKER Jack Louis, 1439 E Balto St

ADDRESS

C.—1-30—M. & T.—250 Bks.

E 59897 HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 59897

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 1121 Whitelock ST. 13-59 WARD)

2-FULL NAME Louis Bates

(a) RESIDENCE NO. 1124 Whitelock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

If married, widowed, or divorced (HUSBAND) of or) WIFE of Ida Bates

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
(45)	45			

CCUPATION OF DECEASED)

(a) Trade, profession or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Issac Bates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Citron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Lewis

(Address) 1124 Whitelock

Filed 1 9 1930 H. M. [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-14-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1930, to Aug. 19, 1930,

that I last saw h— alive on Aug. 19, 1930,

and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Kidney

(duration) yrs. 6 mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & operation

(Signed) Chas. Isaacs, M. D.

, 19 (Address) 3114 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Lawn Cem. Carmel

DATE OF BURIAL 8-16-1930

20 UNDERTAKER [illegible] & Bates

ADDRESS

C.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59898

CERTIFICATE OF DEATH.

45 E 59898

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Women's Hospital ST. 12-19 WARD)

2-FULL NAME Frances Helsey Fayles Clarke

(a) RESIDENCE NO. 1301 St Paul ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

ength of residence in city or town where death occurred 1yr 2 mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (b) HUSBAND of (or) WIFE of Henry Lee Clarke

ATE OF BIRTH (month, day, and year) Jan 17, 1882

AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	48	7	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Benjamin Lee Fayles

11 BIRTHPLACE OF FATHER (city or town) Philadelphia (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Frances Mafell

13 BIRTHPLACE OF MOTHER (city or town) Charleston (State or country) South Carolina

Informant (Address) Henry Lee Clarke 1301 St. Paul St.

Filed 19 1930 H. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Aug. 15, 1930, that I last saw him alive on Aug. 15, 1930, and that death occurred, on the date stated above, at 3 09 P. m. D. L. S. T.

The CAUSE OF DEATH* was as follows:

Chronic intestinal Obstruction

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 30, 1930

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Lilian Arnold Gillett, M. D.

Aug 18, 1930 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Aug 20 1930
20 UNDERTAKER Henry Meinheim & Son Co	ADDRESS Orchard & Mc Culloh Sts

C.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59899

CERTIFICATE OF DEATH.

31 E 59899

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 21-31 WARD

TY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas

(a) RESIDENCE NO. 1107 Denver st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

f married, widowed, or divorced HUSBAND of or) WIFE of Mamie Thomas

ATE OF BIRTH (month, day, and year) 9-13-07

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

IRTHPLACE (city or town) (State or country) Norfolk, Virginia

0 NAME OF FATHER Tom Thomas

1 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

2 MAIDEN NAME OF MOTHER Lillian Thomas

3 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

Informant Hospital Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 19 C. HAMPSON JONES, M. D.

Registrar

MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 26, 19 30, to August 15, 19 30, that I last saw him alive on August 15, 19 30, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Seuser, M. D.

8-15-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL AUG 19 19 1930

20 UNDERTAKER Commissioner Health

ADDRESS

c.—1-30—M. & T.—250 Bks

E 59900

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59900

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 3-4

TY OF BALTIMORE: (NO. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Adams

(a) RESIDENCE NO. 1429 Bounty Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Widower

f married, widowed, or divorced HUSBAND of or) WIFE of Unknown

ATE OF BIRTH (month, day, and year) Mch. 13, 1865

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

IRTHPLACE (city or town) (State or country) Richmond Virginia

0 NAME OF FATHER Primms Adams

1 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Virginia

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) (State or country) UNKNOWN

Informant Hospital Records

(Address) JOHNS HOPKINS HOSPITAL

G 19 1930 HARRISON JONES, M.D.

Registrar

HE MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to Aug. 13, 1930, that I last saw him alive on Aug. 13, 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jenner, M. D.

8-13, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

UNDERTAKER Commissioner Health

DATE OF BURIAL AUG 19 1930 19

ADDRESS

1-30—M. & T.—250 Bks.

E 5990[illegible] HEALTH DEPARTMENT—CITY OF BALTIMORE E 5990[illegible]

CERTIFICATE OF DEATH

114

1-PLACE OF DEATH Baltimore City Hospital — REGISTERED NO. ....

TY OF BALTIMORE: (No. 16-68 ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Grams

(a) RESIDENCE NO. 2334 Forster ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred [illegible] yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	single

married, widowed, or divorced
HUSBAND of
(or) WIFE of —

ATE OF BIRTH (month, day, and year) 1875

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55		—	—	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

IRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER John Grams

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md

Informant Purnell ?
(Address) Baltimore City Hosp.

Filed [illegible] 1939 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-18-30

17 I HEREBY CERTIFY, That I attended deceased from 3-19-30, 19.., to 8-18, 1930,
that I last saw him alive on 8-18-, 1930,
and that death occurred, on the date stated above, at 6 15 Am.

The CAUSE OF DEATH* was as follows:
Ulcerations of small intestines with perforation

(duration) unknown ds.

CONTRIBUTORY (Secondary) Localized peritonitis
(duration) ..... yrs. unknown

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of —
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy findings
(Signed) Hurst M. Duckett, M. D.
, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill	June 20, 1930
20 UNDERTAKER Wilhelm & Cook	ADDRESS 2217 St. Paul St.

C.—1-30—M. & T.—250 Bks.

39892
E 59902

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59902

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. 7-9 WARD)

2-FULL NAME Capt James A Turner

(a) RESIDENCE NO. Salisbury Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

If married, widowed, or divorced (or) HUSBAND of / WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) Apr-18-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sea Captain

(b) General nature of Industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER Edward Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Mary (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

Informant: JOHNS HOPKINS HOSPITAL Records

(Address)

Filed 9 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-19-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1930, to Aug 19, 1930, that I last saw h.im alive on Aug 19, 1930, and that death occurred, on the date stated above, at 1.10 A m.

The CAUSE OF DEATH* was as follows:

Gangrene, arteriosclerosis

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary): Bronchial pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —Amputation Leg

Did an operation precede death? yes Date of 8-16-30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Eduardo H. Cameron M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge, Md — DATE OF BURIAL: Aug 21 1930

20 UNDERTAKER: J. Fischer, Jones — ADDRESS: Forest Ave

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

8-9-62 E 59903

CERTIFICATE OF DEATH.

59903

REGISTERED NO. 118

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) St. Agnes Hospital (WARD)

2-FULL NAME William H Reed (REED)

(a) RESIDENCE NO. 1148 Carroll St., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

f married, widowed, or divorced HUSBAND of Jane Reed

ATE OF BIRTH (month, day, and year) January 16 1866

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	7	2	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal & Ice Business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

IRTHPLACE (city or town) (State or country) St Louis Mo

10 NAME OF FATHER James B Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs Jane Reed

(Address) 1148 Carroll St

H. H. JONES, M. D.

Registrar

Filed 1-9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 12 30, 19..., to Aug 18 30, 19...;

that I last saw h i alive on Aug 18 30, 19... 6 P m.

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Partial Intestinal obstruction

Pelvic abscess

(undetermined origin)

(duration) yrs. mos 2 1 ds.

CONTRIBUTORY (Secondary) Vaso-motor Collapse

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8/18/30

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H H Jones M. D.

8/18, 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL Aug 21 1930

20 UNDERTAKER J. J. Tucker & Sons

ADDRESS 1 to 9 Ave

Cor.—12-9-25—A Co.—200 Bks.

E 59904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48 E 59904

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St 9-17 Ward)

2-FULL NAME Katherine Finegan

(a) RESIDENCE NO. Reisterstown Rd, Pikesville MD Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 1, 1880

7 AGE: Years 50 | Months 5 | Days 17 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County (State or country) Maryland

10 NAME OF FATHER Arthur ~~Finegan~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Triplett

13 BIRTHPLACE OF MOTHER (city or town) Soldier's Delight (State or country) Baltimore County, Md.

14 Informant (Address) Mrs. Bolling Barton Pikesville, Md.

15 Filed 1930 C. H. THOMPSON JONES, M. D. Registrar By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mixed Sarcoma Face & Neck.

(no operation- Autopsy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Keller M. D. (Coroner)

8/19/30 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — Date of Burial: Aug. 20 1930

20 UNDERTAKER [redacted] ADDRESS 1003 West Baltimore St

c.—1-30—M. & T.—250 Bks.

E 59905 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59905

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Maryland University Hospital ST. 4-30 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.

2-FULL NAME Mary Josephine Furlong

(a) RESIDENCE NO. Aberdeen, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred [redacted] yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Child

I married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) July 25, 1929

GE. Years	Months	Days	If LESS than 1 day, hrs. or min.
1	-	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Joseph L. Furlong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County Maryland

12 MAIDEN NAME OF MOTHER Lucy Marie Brass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard County Maryland

Informant Mrs. L. Marie Furlong

(Address) Aberdeen, Md.

Filed [illegible] 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 16, 1930 to Aug. 19, 1930, that I last saw her alive on Aug 19, 1930, and that death occurred, on the date stated above, at 5:55 A.m.

The CAUSE OF DEATH* was as follows:

Dysentery (cause unknown) 1 week (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia 2½ days (duration) yrs. mos. 2½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool exam. Physical exam.

(Signed) R. E. Hudson M. D.

8/19/30, 19 (Address) University of Maryland Hospital

*State the Disease Causing Death, or (in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery

DATE OF BURIAL Aug. 21, 19 30

20 UNDERTAKER [illegible]

ADDRESS 1003 West Baltimore St.

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59906

CERTIFICATE OF DEATH.

16-002 E 59906

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 2625 Ausquith ST., 9-46 (WARD)

2-FULL NAME Louisa M. Dohrmann

(a) RESIDENCE NO. 2625 Ausquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

f married, widowed, or divorced
HUSBAND of—
ot) WIFE of the late August Dohrmann

ATE OF BIRTH (month, day, and year)

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
83	2	23	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Germany

0 NAME OF FATHER Stockelgon

1 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

2 MAIDEN NAME OF MOTHER Not Known

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Eugene H. Dohrman

(Address) 2625 Ausquith St

CLAMPSON JONES, M. D. Registrar

Filed ..... 19 .....

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 6, 1930, to August 18, 1930, that I last saw h alive on August 17, 1930, and that death occurred, on the date stated above, at 730 A m.

The CAUSE OF DEATH* was as follows:

Acute bacillary Dysentery

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Ex Paralysis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Albert Eisenberg M. D.

8/19 1930 (Address) 3025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cemetery Lutherville DATE OF BURIAL Aug 22 30

20 UNDERTAKER Chas E Miller & Son ADDRESS Baltimore

—1-30—M. & T.—250 Blks

E 59907 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59907

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (J.B.) 15-21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. ST.,

2-FULL NAME Percy Grimes

(a) RESIDENCE NO. 1628 Baker St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

eagth of residence in city or town where death occurred 1 D yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mu	Negro	Single

f married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) April 20, 1907

GE	Years	Months	Days 27	If LESS than 1 day, hrs. or min.
,	23	4		

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) 623

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore, Md.

0 NAME OF FATHER George Grimes

1 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

2 MAIDEN NAME OF MOTHER Sidney Chase

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records

(Address)

Filed 9 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17/30

17 I HEREBY CERTIFY, That I attended deceased from 7/21/00, 19, to 8/17/30, 19, that I last saw h m alive on 8/17/30, 19, and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes Clinical + Autopsy

What test confirmed diagnosis?

(Signed) David Seman, M. D.

8/17, 1930 (Address) Baltimore City Hospitals (J.B.)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug 21 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

c.—1-30—M. & T.—250 Bks

E 59908 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 59908

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (C.B.) ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.

2-FULL NAME Alma Monroe

(a) RESIDENCE NO. 103 N. Gilmor st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	Colored	Married

f married, widowed, or divorced HUSBAND of or) WIFE of John Monroe

ATE OF BIRTH (month, day, and year) Jan. 11, 1898

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

IRTHPLACE (city or town) (State or country) Maryland

0 NAME OF FATHER Chas. Franklin Coates

1 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

2 MAIDEN NAME OF MOTHER Victoria Kyler

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records

(Address)

Filed 9 1930 19 at C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to August 18, 1930,

that I last saw her alive on August 18, 1930,

and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Turner, M. D.

8-18, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert to Huntingtown md

DATE OF BURIAL Aug 20 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

c.—1-30—M. & T.—250 Bks.

E 59909

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 59909

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Sinai Hospital ST., 15-58 WARD)

2-FULL NAME David Robinowitz

(a) RESIDENCE NO. 3733 Park Heights Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of /

ATE OF BIRTH (month, day, and year) April - 1904

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	4		

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Charles Rabinowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant J. Lewis

(Address) 739 Balto

Filed AUG 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-19-30

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 19, 1930, that I last saw h.m alive on Aug 19, 1930, and that death occurred, on the date stated above, at 9.55 A.M.

The CAUSE OF DEATH* was as follows:

Chr. valvular heart disease (Rheumatic) mitral stenosis & insuff aortic insuff

(duration) 11 yrs. mos da.

CONTRIBUTORY (Secondary) Acute Bacterial Endocarditis

(duration) 0 yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Milton Brenner M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sylvan W. Cemetery, Woodlawn Circle DATE OF BURIAL 8-20 1930

20 UNDERTAKER Jack Lewis, 1+39 ADDRESS Baltimore

30—M. & T.—100 B—50L

E 59910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59910

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Passidunk Ho (WARD) 12-51

2-FULL NAME Wm Wright

(a) RESIDENCE NO 2120 Oak ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

DATE OF BIRTH (month, day, and year) 1894

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer do

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Wm Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Smithers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Rose Forsyth

(Address) 2120 Oak St

Filed Aug 20 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 17 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Clark M. D.

Aug 18 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

20 UNDERTAKER Eugene Heitz

DATE OF BURIAL 8-20 1930

ADDRESS Dover

1-30—M. & T.—250 Bks.

59911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 L 59911

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals ST. 16-26 (WARD)

TY OF BALTIMORE: (No. .....

2-FULL NAME Charles Hunter

(a) RESIDENCE NO. 807 W. Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 21 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	colored	single

married, widowed, or divorced
HUSBAND of
(or) WIFE of —

ATE OF BIRTH (month, day, and year) 1899

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	?	?	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Wrks

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer Hotel Baltimore

IRTHPLACE (city or town) Hamburg
(State or country) Pa.

0 NAME OF FATHER Elmer Hunter

1 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Pa

2 MAIDEN NAME OF MOTHER Viola Bailey

3 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Pa.

Informant (Address) Mrs. Baltimore City Hospitals

17 Filed AUG 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-1930

17 I HEREBY CERTIFY, That I attended deceased from 8-11-, 1930, to 8-16-, 1930, that I last saw him alive on 8-16-, 1930, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Rt Pneumonia & Pyonatic Cystitis (urinary Middle)

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings

(Signed) Fred M. Dudrow M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Auburn

DATE OF BURIAL 8-19 30

UNDERTAKER Dennis Eastern

ADDRESS 916 Baltimore

c.—1-30—M. & T.—250 Bks

E 59912 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ E 59912

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST., 10-13 WARD)

TY OF BALTIMORE: (NO.

2-FULL NAME Geneva Florence Day

(a) RESIDENCE NO. 707 N. Eden st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	Colored	Single

f married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) Dec. 11, 1903

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	8	7	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

IRTHPLACE (city or town) (State or country) Washington, D.C.

10 NAME OF FATHER Louis Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Lynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Records

(Address)

Filed 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1930, to Aug. 18, 1930,

that I last saw her alive on Aug. 18, 1930,

and that death occurred, on the date stated above, at 4.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Seuner, M. D.

8-18, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cemetery DATE OF BURIAL Aug 21 1930

20 UNDERTAKER Chas. H. Johnson ADDRESS 476 N. Caroline St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59916

CERTIFICATE OF DEATH.

65-001 E 59913

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4114 Penhurst Ave (St.) (Ward)

2-FULL NAME Rose A. Prunty

(a) RESIDENCE NO. 4466 E. 20th St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced: HUSBAND of (or) WIFE of: Single

7 DATE OF BIRTH (month, day, and year): Dec 17, 1880

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Typist

(b) General nature of industry, business, or establishment in which employed (or employer): Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Prunty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anna C. Culbreth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant (Address): Mrs Harry Sherman 4466 E 20th St

15 Filed: C. HARRISON JONES, M. D. Registrar

0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1930. to August 20 1930.

that I last saw her alive on Aug. 18, 1930

and that death occurred, on the date stated above, at 2.40 A m.

The CAUSE OF DEATH* was as follows:

Leukocythemia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Heart failure (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Towns, M. D.

(Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Aug 22, 1930

20 UNDERTAKER: John A. Moran

ADDRESS: 3.00 E Balto St

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46E 59914

59914

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals ST. 18-24 WARD)

TY OF BALTIMORE: (NO. .....

2-FULL NAME Annie Blakewell

(a) RESIDENCE NO. 48 S Stockton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	Col Colored	Widowed.

married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown.

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
9		—	—	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

RTHPLACE (city or town) Baltimore
(State or country) Md.

0 NAME OF FATHER Charles Ford

1 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Pa.

2 MAIDEN NAME OF MOTHER Mary Cook.

3 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md.

Informant Records of Baltimore City Hosps
(Address)

Filed 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-30

17 I HEREBY CERTIFY, That I attended deceased from 6-20-, 1930., to 8-16-, 1930.,
that I last saw h alive on 8-16-, 1930,
and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of cervix with local metastasis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy findings

(Signed) Fred M. Dunkum M. D.

, 19 (Address) Baltimore City Hosps

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middlebury Cem

DATE OF BURIAL Aug 20th 1930

20 UNDERTAKER A. Jones

ADDRESS W. S. Edmonson

c.—1-30—M. & T.—250 Bks.

E 59916 E 59915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

148

REGISTERED NO. E 59915

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3-4 WARD)

2-FULL NAME Maggie Johnson

(a) RESIDENCE No. 418 Bethel St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	married

f married, widowed, or divorced HUSBAND of or) WIFE of Richard

ATE OF BIRTH (month, day, and year) Oct 22-1901

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	9	26	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

IRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Elijah Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Adeline Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va -

Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

1 1930 H. [illegible] JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18-30

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1930, to Aug 18, 1930, that I last saw her alive on Aug 18, 1930, and that death occurred, on the date stated above, at 1232 P m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pregnancy - multi

Trauma (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes autopsy - record

What test confirmed diagnosis? Chemistry -

(Signed) Charles M McLane M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edbury cemetery

DATE OF BURIAL aug 20 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1681 Orleans st

c. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 V E 59916

CERTIFICATE OF DEATH

59916 REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1515 Lanvale ST. W. 16-22 WARD)

2—FULL NAME Alonzo S. Curry

(a) RESIDENCE NO. 1515 Lanvale St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

married, widowed, or divorced HUSBAND of (or) WIFE of: Pauline

DATE OF BIRTH (month, day, and year): July 26-1904

AGE: Years 26 Months 0 Days 27 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va.

NAME OF FATHER: Joseph J. Curry

BIRTHPLACE OF FATHER (city or town) (State or country): Va

MAIDEN NAME OF MOTHER: Louise Holland

BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: Pauline Curry

(Address): 1515 Lanvale St

Filed Aug. 19 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12 1930 to Aug. 18 1930

that I last saw him alive on Aug. 18 1930 and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Jas. Ed. Bell M. D.

(Address) 713 N. Gilmor

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star

DATE OF BURIAL: 8/21/1930

20 UNDERTAKER: Jno. Geo. H. Holland

ADDRESS: 1651 Druid Pk.

c.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59917

REGISTERED NO. E 59917

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 515 W. Franklin ST. 18-26 WARD)

2-FULL NAME Jesse Gilliard

(a) RESIDENCE NO. 515 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) Oct 10-1912

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	17	9	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Shine

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md
(State or country)

10 NAME OF FATHER Jesse Gilliard

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Langley

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

Informant Marie Bryant
(Address) 515 W. Franklin St

Filed . 19 C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1 , 1930 , to Aug 16 , 1930 .

that I last saw him alive on Aug 16 , 1930 .

and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 2 mos. 16 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pelletanin , M. D.

, 19 (Address) 517 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Aug 19 30

20 UNDERTAKER Edward O'Hanley ADDRESS 3?? Pikesville

or.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59918

CERTIFICATE OF DEATH

74001 ✓ E 59918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bon Secours Hospital St., 3-4 Ward)

2 FULL NAME Jozef Zelichowski

(a) RESIDENCE NO. 710 S. Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Dominika Zelichowski

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steelworker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

10 NAME OF FATHER Unknown Zelichowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Dominika Zelichowski
(Address) 710 S. Bond St.

15 FILED ..... 19..... E. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. 1/4 ds.

CONTRIBUTORY (Secondary) S. 300 - D 178 unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 710 S Bond
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) James M Hanlon M. D.
8-19-1930 (Address) 709 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Holy Rosary	ADDRESS

20 UNDERTAKER John M Weber & Sons

Spec—12-23-21—E.P.R.S.—400 Lbs.

59919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 59919

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1318 W. North Ave. St., 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alsey M. Whittemore

(a) Residence No. 1318 W. North Ave. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Married

6-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Rawlings Whittemore

7-DATE OF BIRTH (month, day and year): April. 12. 1905

8-AGE: 25 yrs. 3 mos. 27 ds.

If LESS than 1 day, hrs. or min.?

9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

10-BIRTHPLACE (city or town) (State or Country): Balto. Md.

10-NAME OF FATHER: Charles B. Wright

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Mary A. Boyln

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Westminster, Md.

14-(Informant): Mary A. Wright

(Address): 1318 W. North Ave.

15-HAMPSON JONES, M. D. Registrar.

AUG 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug. 19, 1930

17- I HEREBY CERTIFY, That I attended deceased from June 30 1930 to Aug. 19 1930

That I last saw h. er alive on Aug. 19 1930

and that death occurred, on the date stated above, at 10.30 A. M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Chronic Parenchymatous Nephritis

(Duration) 3 yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. D.

Aug. 20, 1930 (Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster St Johns Cemetery Md

DATE OF BURIAL: aug. 23, 1930

20-UNDERTAKER: Curley & Co. Inc

ADDRESS: 1021 N. Eutaw Pl.

E 59920 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59920

CERTIFICATE OF DEATH.

REGISTERED NO. 138

1-PLACE OF DEATH West Balt. Gen. Hosp

CITY OF BALTIMORE: (No.) Rayner + Dukeland ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Campbell

(a) RESIDENCE NO. 920 N. Bond ST., WARD D

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C.	Married

If married, widowed, or divorced (or) WIFE of Grover C. Campbell.

DATE OF BIRTH (month, day, and year) Dec - 1911.

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	19	— 8	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N. C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

Informant Grover C. Campbell

(Address) 920 N. Bond St.

1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug 18, 1930, that I last saw h a alive on Aug 18, 1930 and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Salpingitis - (Strep) (6 weeks)

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) - Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 15

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. Eichman, M. D.

, 19 (Address) W Balt. Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid H. C.

DATE OF BURIAL 8-20 1930

20 UNDERTAKER Dulin Taylor

ADDRESS 716 Druid

or.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59921

CERTIFICATE OF DEATH

74-001

E 59921

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 513 Pierce St. (or Ward) 17-25

2-FULL NAME George A Mollow

(a) RESIDENCE NO. 513 Pierce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Negro	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Mollow

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor 870
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Daniel Easton
(Address) 911 Penna Ave

15 Filed 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

Aug 20, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 8-22 1930

20 UNDERTAKER Frank Evans

ADDRESS 511 Eutaw

c.—1-30—M. & T.—250 Bks

(Gettier) ✓

E 59922 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59922

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) Mercy Hospital St. 28-64 (Ward)

2-FULL NAME John F Gettier

(a) RESIDENCE NO. 5201 Sunnyside Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word)
M	W	Widowed.

If married, widowed, or divorced (or) HUSBAND of (or) WIFE of Ida Gettier.

ATE OF BIRTH (month, day, and year) July 21 1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	—	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer) Estimator

(c) Name of employer Flint & Burns Co.

BIRTHPLACE (city or town) (State or country) Maryland.

10 NAME OF FATHER John L Gettier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara Weis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

Informant Archdiocesan Records.

(Address)

C. HAMPSON JONES, M. D.

Filed AUG 1930 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1930

17 I HEREBY CERTIFY, That I attended deceased from August 16, 1930, to August 19, 1930, that I last saw h in alive on August 19, 1930, and that death occurred, on the date stated above, at 9:55 P m.

The CAUSE OF DEATH* was as follows:

Cardio renal disease

(duration) Indeterminate yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia (duration) undetermined yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7-9-30

Was there an autopsy? No

What test confirmed diagnosis? Laboratory -

(Signed) William L. Fargo M. D.

Aug 19 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemt

DATE OF BURIAL Aug 23 1930

20 UNDERTAKER Rettaman & Love

ADDRESS 1723 W Lafayette Ave

—1-30—M. & T.—250 Bks.

E 59923 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 59923

CERTIFICATE OF DEATH

44

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 13 S. Lynnord ST. 6-11 WARD)

2-FULL NAME Emily Catherine Ingle

(a) RESIDENCE NO. 13 S. Lynnord ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

X | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word)
Female | White | Widow

married, widowed, or divorced HUSBAND of (or) WIFE of John H. Ingle

ATE OF BIRTH (month, day, and year) Aug 21, 1861

GE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	68	11	21	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Md

0 NAME OF FATHER Paul P. Ward

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md

2 MAIDEN NAME OF MOTHER Dont Know

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant John H. Ingle
(Address) 13 S. Lynnord Ave

C. HAMILTON JONES, M. D.

0-1930 . 19 Aug 24 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1930, to Aug 20, 1930, that I last saw her alive on Aug 20, 1930, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Carcinomatosis - Carcinoma of stomach & liver

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Erwin B. Wallace M.D.

, 19 (Address) 1041 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Solomons Island

DATE OF BURIAL Aug 21 1930

20 UNDERTAKER John Ulrich

ADDRESS Edmonson

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59924

CERTIFICATE OF DEATH.

E 59924

REGISTERED NO. 27-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 200 Wyndhurst Ave (WARD) 27

2-FULL NAME Florence Gill Barr

(a) RESIDENCE NO. 200 Wyndhurst Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Benj M. Barr

ATE OF BIRTH (month, day, and year) Dec 26 1867

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

IRTHPLACE (city or town) (State or country) Blackwood N J

0 NAME OF FATHER Robert H Scarlett

1 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

2 MAIDEN NAME OF MOTHER Anna C Brown

3 BIRTHPLACE OF MOTHER (city or town) (State or country) N J

Informant (Address) Mr Benj M Barr 200 Wyndhurst ave

1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1929, to Feb 6, 1930, that I last saw h[illegible] alive on Feb 6, 1930, and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (Coron)

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis Radial

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H E Hurlett M. D.

8/19, 1930 (Address) 1403 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 21 1930
20 UNDERTAKER Chas O Mitchell & Sons	ADDRESS 1700 Eastern Ave

c.—1-30—M. & T.—250 Bks

E 59925 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59925

31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

TY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Somers

(a) RESIDENCE NO. 719 S. Ellwood ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

f married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) Aug. 13, 1887

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	0	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER George Somers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cruscilla Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records

(Address)

Filed 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1929, to Aug. 19, 1930, that I last saw him alive on Aug. 19, 1930, and that death occurred, on the date stated above, at 7.05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Tenner, M. D.

8-19-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Aug 22 1930

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore St. & Broadway

—1-30—M. & T.—250 Bks

E 59926 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-00/E 59926

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 672 South Ann ST., WARD)

2-FULL NAME Louisa Lee Stevenson

(a) RESIDENCE NO. 672 South Ann ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 21 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Widowed

f married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) Feb - 1878

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	6		

CCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town)
(State or country) Ala.

10 NAME OF FATHER Albert Malcher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ala.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ala

Informant Annie [illegible]
(Address) 672 South Ann St

0-1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Aug 17, 1930,
that I last saw h[illegible] alive on Aug 17, 1930,
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemtery

DATE OF BURIAL 8/21 19 30

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1399 Hanover St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59927

CERTIFICATE OF DEATH.

31 E 59927

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 N. Rose St. ST. 7-12 WARD)

2-FULL NAME John Tomich

(a) RESIDENCE NO. 814 N. Rose St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 17, 1904.

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
25	yrs.	7	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

10 NAME OF FATHER: Andrew Tomich.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Tinie Pilmy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia.

14 Informant: Andrew Tomich. (Address) 814 N. Rose St.

15 Filed Aug 22 1930 C. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1930

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to Aug 20, 1930, that I last saw him alive on Aug 20, 1930, and that death occurred, on the date stated above, at 4 00 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray of chest

(Signed) Joseph Pokorny, M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL Sept 23 1930

20 UNDERTAKER: August Pasek ADDRESS 2406 E. Ashland ave.

20—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59928

CERTIFICATE OF DEATH

31 ✓

E 59928

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. WARD 16-26

2-FULL NAME Alton McLandon

(a) RESIDENCE NO. 603 W. Carey ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: Col. | 5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Eileen Landon

DATE OF BIRTH (month, day, and year): Jan 24 - 1905

AGE: Years 25 | Months 1 | Days 23 24 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: Alton Landon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant (Address): Eileen Landon 1418 N. Mount

FILED Aug 18 1930 (192) HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and hour): Aug 17 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Hoffheimer M. D. Coroner

Aug 18 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. DATE OF BURIAL: Aug 21 19 30

20 UNDERTAKER: Samuel Hartsley ADDRESS 578 Mt Belle

c.—1-30—M. & T.—250 Bks.

Dr Pelletier 814 Hamilton Ter

HEALTH DEPARTMENT—CITY OF BALTIMORE

929

CERTIFICATE OF DEATH.

29 E 59929

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 906 N Howard ST. 11-24 WARD)

2-FULL NAME John C. Russell

(a) RESIDENCE NO. 906 N. Howard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mary Russell

DATE OF BIRTH (month, day, and year): Feb. 6, 1873

AGE: Years 57; Months 6; Days 14; If LESS than 1 day, ...hrs. or ....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship Wright

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Sedon Co

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: John Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Kavonaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Eliza L Cannon

(Address): 906 N Howard St

Filed JUL 1 1930 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30. 1930

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1930, to July 30 1930

that I last saw h.. alive on July 20 1930

and that death occurred, on the date stated above, at 11,15 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 4 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelletier M. D.

(Address) 814 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral

UNDERTAKER: William Cook

DATE OF BURIAL: 8/23 1930

ADDRESS: 1217 E Fayette St

c.—1-30—M. & T.—250 Bks.

Dr Gilroy Wm Cook

E 59930 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 59930

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE. (No.) 3609 Oakmount Ave ST. 27-56 WARD)

2-FULL NAME Ferdinand A Lehnert

(a) RESIDENCE NO. 3609 Oakmount Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Mary E Lehnert

ATE OF BIRTH (month, day, and year) Aug 18 1881

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Stat Mf Co.

IRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Charles A Lehnert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mary E Lehnert

(Address) 3609 Oakmount Ave.

Filed 8-21 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930 to Aug 18, 1930,

that I last saw him alive on Aug 18, 1930,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J P Gilroy M. D.

8/19, 1930 (Address) 611 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL 8/21 1930

20 UNDERTAKER J H Cook

ADDRESS 1217 St Paul St

c—1-30—M. & T.—250 Blks

E 5993I HEALTH DEPARTMENT—CITY OF BALTIMORE E 5993I

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 1508 Clifton ave ST. 13-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard T. Mayo

(a) RESIDENCE NO. 1508 Clifton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 54 yrs. 9 mos. 3 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 16 1875

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	9	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) High Mayo Dept

(c) Name of employer City of Balto

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Leonard T. Mayo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Haven

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs. Geo. B. Evans

(Address) 1508 Clifton

Filed 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Aug 19, 1930, that I last saw h[illegible] alive on Aug 19, 1930 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) E. H. Ellen M. D.

(Address) 2707 W. Fronta

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Aug 22 1930

20 UNDERTAKER Harry W. Ellen

ADDRESS 1944 W. Northan

Spec.—1-10-21—M&T—1500 Bks.

E 59932 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-001 E 59932

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 W. Fayette ST. 14-27 WARD)

2-FULL NAME Baby girl Vesta Blanch Robertshaw

(a) RESIDENCE NO. 1531 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8/17/30

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	0	0	0	

7 OCCUPATION OF DECEASED —

(a) Trade, professinn or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore, Md

10 NAME OF FATHER Ambrose Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Vesta Blanch Robertshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant

(Address)

15 Filed 8 31 1930 C. HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1930, to Aug 17, 1930, that I last saw her alive on Aug 17, 1930, and that death occurred, on the date stated above, at 3, 30 8 m.

The CAUSE OF DEATH* was as follows:

Premature (20 wks)

5 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Louis F. Longfellow, M. D.

8 20 1930 (Address) 1 W. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: FETUS DESTROYED — DATE OF BURIAL 19

20 UNDERTAKER: By Burning — ADDRESS

Bruce Bacoat.

2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59933

CERTIFICATE OF DEATH

31 ✓ E 59933

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1105 N Dallas St ST. 8-13 WARD)

2—FULL NAME Bruce Bacoat

3(a) RESIDENCE NO. 1105 N Dallas St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

If married, widowed, or divorced
BUSBAND of (or) WIFE of Mabel Bascoat

6 DATE OF BIRTH (month, day, and year) June 8, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Col

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S.C.

10 NAME OF FATHER Albert Bacoat

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Mozell Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

Informant Mabel Bacoat

(Address) 1105 N. Dallas St

Filed Aug 21 1930 C. HAMPSON JONES, M. D. Registrar

T 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1930

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1930, to Aug 19, 1930, that I last saw him alive on Aug 19, 1930, and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Phthisis Pulmonalis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia Phthisis Pulmonalis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) C. D. Hall, M. D.

19 (Address) 1426 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dorsville S.C.	Aug 21 1930
20 UNDERTAKER Mrs J. A. Locks	ADDRESS 1302 Jefferson

c.—1-30—M. & T.—250 Bks.

E 59934 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59934

74-001

CERTIFICATE OF DEATH.

REGISTERED NO._____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 701 S. Broadway (ST.) 2-4 (WARD)

2-FULL NAME Rebecca Waldorf

(a) RESIDENCE NO. 701 S. Broadway ST., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of Henry Waldorf

DATE OF BIRTH (month, day, and year) Mch. 3rd. 1860

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

10 NAME OF FATHER Jacob Haas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Babette Strasburger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Mr. Milton Waldorf
(Address) 701 S. Broadway

Filed AUG 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Aug 20, 1930, that I last saw h- alive on Aug 20, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I. Frederick Lentz, M. D.

8/20, 1930 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 8/22/1930

20 UNDERTAKER David Sonnheim's Son

ADDRESS 1902 Eutaw Place

Cor.—10-10-29—A Co.—100 Bks.

E 59935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Time of burial 1:30 pm Aug. 22-30
J. Hudnut Hospital Burg. Exam.
E 59935

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. University Hospital St., 4-30 Ward)

2-FULL NAME Hattie Johnson

(a) RESIDENCE NO. 411 Lemon St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Hattie Woody

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Hospital Record
(Address)

21 1930 19 C. HARRISON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) August 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Kellert M. D.

8/18. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug 22 1930

20 UNDERTAKER R. Williams 1515 McElderry St

ADDRESS

c.—1-30—M. & T.—250 Blks.

E 59936
239773

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-03 E 59936

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 5-8 (WARD)

2-FULL NAME Leroy Hawkins

(a) RESIDENCE NO. 536 N. Central ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) July-7-1930

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Benny Chester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant JOHNS HOPKINS HOSPITAL Records

(Address) C. HAMPSON JONES, M.

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19-1930

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Aug 19, 1930, that I last saw h[illegible] alive on Aug 19, 1930, and that death occurred, on the date stated above, at 8 20 p m.

The CAUSE OF DEATH* was as follows:

Congenital Pyloric Stenosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Campbell Goodwin, M. D.

8/20, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery DATE OF BURIAL Aug 21 1930

UNDERTAKER Chas. H. Johnson ADDRESS 416 N. Caroline St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59937

E 59937

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 5-8 Ward)

2-FULL NAME Mary Elizabeth Beaver Aaron.

(a) RESIDENCE NO. 104 East St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Aaron

6 DATE OF BIRTH (month, day, and year): 1890

7 AGE: Years 40 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Hagerstown (State or country) Md

PARENTS

10 NAME OF FATHER: Wm. Gassaway

11 BIRTHPLACE OF FATHER (city or town): unknown (State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): (State or country)

14 Informant: Charles Aaron (Address) 104 East St.

15 Filed..... 19.. Registrar C. HAMPSON JONES, M. D.

AUG 21 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Rupt. tubal pregnancy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

Aug 21, 1930 (Address) 1637 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn Cemetery Date of Burial Aug 24 1930

UNDERTAKER: Chas. W. Johnson ADDRESS 446 N. Carey St.

Cor.—10-10-29—A Co.—100 Bks.

E 59938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 90 E 59938

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 406 N. Stricker St. St. 9-27 Ward)

2-FULL NAME Octavia Lassiter.(C)

(a) RESIDENCE NO. 406 N. Stricker St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married.

5a If married, ~~widowed or divorced~~ HUSBAND OF (or) WIFE of Hardy Lassiter.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	84	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Hardy Lassiter.(C) husband.
(Address) 406 N. Stricker St.

15 Filed ... 19... C. HAMPSON JONES, M. D.
Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Edw. M. Leonard, M. D.

8/18, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL Aug 21 1930

20 UNDERTAKER Joseph A Lucky — ADDRESS 409 Monument St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59939

188-012

REGISTERED NO. E 59939

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH L.Md.E.R.Grain Elevator.

City of Baltimore: (No. Port Covington. St. 14-20 Ward)

2-FULL NAME Selby E.Jordon.(C)

(a) RESIDENCE NO. 1610 Druid Hill Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 31, 1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Jordon.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Clark.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant John Jordon.(C father.
(Address) Reisterstown, Md.

Filed AUG 21 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed under a falling wall due to an explosion in L.Md.E.R.Grain Elevator. Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.

8/21. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Lukes Cemetery Reisterstown

DATE OF BURIAL Aug 23 1930

20 UNDERTAKER J. F. Edwards Reisterstown Md

ADDRESS

sc.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59940 — 31 E 59940

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1436 Light St. ST. 13-23 WARD)

2—FULL NAME James Harry Vinyard

(a) RESIDENCE NO. 1436 Light St ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Vinyard

DATE OF BIRTH (month, day, and year) Feb. 14 1880

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	6	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER James Vinyard

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Kercher

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

Informant Mrs. Hoffman

(Address) 1436 Light St.

Filed 2 1 1930, 19 — RAYMOND JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to Aug. 20, 1930, that I last saw him alive on Aug. 20, 1930, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite

(Duration) yrs. mos. ds.

Exhaustion

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. E. Caulprod, M. D.

8/21, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 8/22 1930

20 UNDERTAKER J. Frew McCully

ADDRESS 130 E. Fort

2-29-28—L. F. S.—500 Bks.

Henry F. Heil

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59941

CERTIFICATE OF DEATH

90

E 59941

REGISTERED NO. 24-344

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Battery Ave ST. (WARD)

2—FULL NAME Henry F. Heil

(a) RESIDENCE NO. 1514 Battery Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

7 If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Heil

8 DATE OF BIRTH (month, day, and year) Sept. 9 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	11	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER H. Heil

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Wiltwin

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant Mrs. Heil

(Address) 1514 Battery Ave

Filed 1930 H. HANSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-19-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Aug 19, 1930.

that I last saw him alive on Aug 19, 1930

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Arterial sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis

Indigestion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D.

8/19, 1930 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 8/22 1930

20 UNDERTAKER J. Few McCully

ADDRESS 430 E. Fort

c.—1-30—M. & T.—250 Bks

59942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131 E 59942

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3317 Hudson ST. 76-1 WARD)

2-FULL NAME John Klass

(a) RESIDENCE NO. 3317 Hudson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Oct. 23. 891

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	9	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Conrad Klass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hamer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

Informant Elizabeth Klass.

(Address) 1045 N. Bouldin St.

Filed ... 1930 C. HARRISON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 - 1930

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930, to Aug - 21 -, 1930,

that I last saw him alive on Aug - 21 -, 1930,

and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pyo-nephrosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) N. P. Davidson, M. D.

, 19 (Address) 3035 Boonmead

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL aug 24 1930

20 UNDERTAKER George W Zirkler

ADDRESS 1737 Eager St.

c.—1-30—M. & T.—250 Blks

E 59943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ~ E 59943

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 3-5)

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Phillip

(a) RESIDENCE NO. 1001 Saulisbury Court ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced (HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) July 13, 1885

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	1	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) New Orleans Louisiana

10 NAME OF FATHER George Phillip

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisiana

12 MAIDEN NAME OF MOTHER Ada Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

Informant Hospital Records

(Address) JOHNS HOPKINS HOSPITAL

Filed AUG 21 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29, 19 30, to Aug. 18, 19 30, that I last saw him alive on Aug. 18, 19 30, and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jeuner, M. D.

8-18 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

UNDERTAKER .....

ADDRESS .....

Commissioner Health

AUG 21 1930

c.—1-30—M. & T.—250 Bks. Susan A Clapsaddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59944

CERTIFICATE OF DEATH.

129 E 59944

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 3120 N. North Ave ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan A. Clapsaddle

(a) RESIDENCE NO. 3120 N. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

f married, widowed, or divorced HUSBAND of (or) WIFE of Frank M. Clapsaddle

ATE OF BIRTH (month, day, and year) 5-21-1863

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	✓	19	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Carroll Co. Md.

0 NAME OF FATHER David Simms

1 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

2 MAIDEN NAME OF MOTHER — Sims

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant (Address) 3120 W. North Ave.

Filed AUG 20 1930 E. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19-1930

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1930, to August 19th, 1930, that I last saw h[illegible] alive on August 19th, 1930, and that death occurred, on the date stated above, at 8-20 P.M. S.T.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. L. Hammett, M. D.

Aug 21 1930 (Address) 1924 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL 8-21-30

20 UNDERTAKER George E. Duffy Inc

ADDRESS 1735 Pennsylvania Ave

c—1-30—M. & T.—250 Bks.

E 59945

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59945

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 2727 N. Charles ST. 12-50 (WARD)

2-FULL NAME John T. Bayless

(a) RESIDENCE NO. 2727 N. Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

eagth of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	widowed

If married, widowed or divorced HUSBAND of (or) WIFE of Emily Wilson

ATE OF BIRTH (month, day, and year) July 21 1856

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74		25	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Harford Co. (State or country) Md.

10 NAME OF FATHER Wm. T. Bayless

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah E. Ramsay

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

Informant Mrs. Mary B. Mason

(Address) 2727 N. Charles St.

Filed 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 20, 1930, that I last saw him alive on Aug 20, 1930, and that death occurred, on the date stated above, at 9 35 P m.

The CAUSE OF DEATH was as follows:

Hepatic Cirrhosis

Myocarditis

(duration) 2 yrs.? mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Moody, M. D.

, 19 (Address) 1402 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmony Md.	Aug 22 19 30
20 UNDERTAKER	ADDRESS
John A. Mitchell & Son	1501 Eutaw Pl.

c.—1-30—M. & T.—250 Bks.

E 59946 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59946

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland University Hospital

CITY OF BALTIMORE: (No. 4-30 ST. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Penn

(a) RESIDENCE NO. Fullerton Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 15 1873

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	9	6	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Cato Co
(State or country) Maryland

10 NAME OF FATHER John W. Penn

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah A. Blakman

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

Informant Mae E. Penn
(Address) Fullerton Md.

Filed 1930 19 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21, 1930.

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1930, to August 21, 1930, that I last saw h[illegible] alive on August 21, 1930, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:
Septicemia, [illegible]

Known (duration) yrs. 1 mos 17 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency, acute
sudden (duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Probably at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Course of Disease.

(Signed) C. E. Sanders M. D.

19 (Address) Maryland Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Camp Chapel Cemetery	Aug. 24 1930
20 UNDERTAKER	ADDRESS
Frank Lassahn & Sons	1401 Addison Rd.

c.—1-30—M. & T.—250 Bks.

E 59947 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59947

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Druid Hosp

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST. 7-13 WARD)

2-FULL NAME Rose Stottlemeyer

(a) RESIDENCE NO. Temple Garden Apts ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of or) WIFE of: George Stottlemeyer

ATE OF BIRTH (month, day, and year): March 20 1879

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	5	0	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: At Home

IRTHPLACE (city or town) (State or country): West Va

10 NAME OF FATHER: Wilmont H. Cadwallader

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Mary C Kease

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Va

Informant: Samuel Stottlemeyer

(Address) Temple Garden Apts

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-20-30

17 I HEREBY CERTIFY, That I attended deceased from 8-11, 1930, to 8-20, 1930, that I last saw her alive on 8-20, 1930, and that death occurred, on the date stated above, at 8:10 P m. S.T.

The CAUSE OF DEATH* was as follows:

Chr. Nephrosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton B Kirsh, M. D.

, 19 (Address) Druid Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 8/23 1930

20 UNDERTAKER: J M Cook — ADDRESS: 1214 E Fond St

)—M. & T.—100 B—50L

E 59948

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59948

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 4006 Gunsdale ST. 15-64 (WARD)

2-FULL NAME Emma Blandford Dorleman

(a) RESIDENCE NO. 4005 Gunsdale ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 8 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas F

DATE OF BIRTH (month, day, and year) July 11 1869

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	9	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

19 NAME OF FATHER Jacob Blandford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth McCulloch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Thomas F. Dorleman

(Address) 4005 Gunsdale St

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

..... (duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) ..... M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 8/22 1930

20 UNDERTAKER Henry W. Deaver & Son

ADDRESS 505 N. Calvert

...c.—1-30—M. & T.—250 Bks.

23925 E 59949

HEALTH DEPARTMENT—CITY OF BALTIMORE

138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

...TY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-22 WARD)

2-FULL NAME Nannie Henson

(a) RESIDENCE NO. 806 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Lewis

...ATE OF BIRTH (month, day, and year) Mar-3-1883

...GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	47	5	18	

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

...IRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Christian Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nannie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-21-1930

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Aug 21, 1930, that I last saw her alive on Aug 21, 1930, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Septicaemia (B. Coli) Broncho pneumonia

Pyelonephritis (B. Coli)

(duration) yrs. mos 27 ds.

CONTRIBUTORY (Secondary) Pelvic Abscess (B Coli)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes-

What test confirmed diagnosis? Blood culture Urine Culture Autopsy

(Signed) H. S. Everett M. D.

8/21, 1930 (Address) The Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Aug 31 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

C.—1-30—M. & T.—250 Bks

E 59950

E 59950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

REGISTERED NO. 16-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1103 Woodyear ST. ..... WARD)

2-FULL NAME Beatrice Spriggs

(a) RESIDENCE NO. 1103 Woodyear ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph W. Spriggs

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~ work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Dunsville Va
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Paulmie Coles

13 BIRTHPLACE OF MOTHER (city or town) Danville Va
(State or country)

Informant Mrs. Spriggs
(Address) 1103 Woodyear St.

Filed 8-21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17/30

17 I HEREBY CERTIFY, That I attended deceased from 7-12- , 1930, to 8-19- , 1930.

that I last saw her alive on 8-19- , 1930,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ~~Unknown~~ mos. ..... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. and C. A. Saunders, M. D.

8-20- 1930 (Address) 1024 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL Aug 30 1930

20 UNDERTAKER Mrs. Katie R. Wilson

ADDRESS 327 N. Schroeder St

c.—1-12-23—M&T—500 Bks.

59951

HEALTH DEPARTMENT—CITY OF BALTIMORE

1142 59951

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1602 W. Lexington ST., 19-27 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Lee Spencer

(a) RESIDENCE NO. 1603 W. Lexington ST., 19 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) 1/29/1922

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	8	2-3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: William A. Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Beaufort Co. S.C.

12 MAIDEN NAME OF MOTHER: Rosie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

Informant (Address): Sammy Spencer 1603 W. Lexington

Filed 8-27 1930 19 H. J. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/1930

17

I HEREBY CERTIFY, That I attended deceased from 8-20, 19 30, to 8-27, 19 30,

that I last saw her alive on 8-25, 19 30,

and that death occurred, on the date stated above, at 12:21 m.

The CAUSE OF DEATH* was as follows:

Unknown Origin - probably Acute Indigestion followed by acute Collapse.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Duodenal Indigestion

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptomatology

(Signed) [illegible], M. D.

, 19 (Address) 709 Mansfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Aug 23rd 19

20 UNDERTAKER: A. Jones ADDRESS: N. Gilmor

c.—1-30—M. & T.—250 Bks.

59952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

145 001
E 59952
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
TY OF BALTIMORE: (No. Sinai Hospital St. 7-10 WARD)

2-FULL NAME Mrs. Barbara Ruppert

(a) RESIDENCE NO. 528 N. Milton Ave st., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

If married, widowed, or divorced
HUSBAND of
or) WIFE of J. August Ruppert

DATE OF BIRTH (month, day, and year) Aug 17-1903

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27		7	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER Conrad Baer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant August Ruppert
(Address) 528 N. Milton Ave

Filed ... 19 ... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 21, 1930,
that I last saw her alive on Aug 21, 1930
and that death occurred, on the date stated above, at 6 05 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular disease - mitral stenosis and insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown -
Did an operation precede death? Yes Date of Aug 15. 1930
Cesarean section - sterilization
Was there an autopsy? no
What test confirmed diagnosis? Clinical course
(Signed) Archie Robert Cohen M. D.
, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 23 1930
20 UNDERTAKER Geo M. Smith & Son	ADDRESS 811 N. Eutaw St.

C.—1-30—M. & T.—250 Blks.

VE 59953

HEALTH DEPARTMENT—CITY OF BALTIMORE

135

CERTIFICATE OF DEATH.

E 59953

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Baltimore Maryland ST. 15-58 WARD)

2-FULL NAME Mr. Isaac Rothman

(a) RESIDENCE NO. 4315 Pimlico Rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced (h) HUSBAND of (or) (w) WIFE of Esther Rothman

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Isaac Rothman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Berkowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Benj Rothman
(Address) 4315 Pimlico Rd.

Filed AUG 24 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22/30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1930, to Aug 22, 1930, that I last saw him alive on Aug 22, 1930, and that death occurred, on the date stated above, at 10:5 A m.

The CAUSE OF DEATH* was as follows:

Uremia & cardiac failure

(duration) yrs. 0 mos 10 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hyp

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? 4315 Pimlico Rd

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Urea determination

(Signed) Meyer Mehr Bayless, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lochearn Rosedale

DATE OF BURIAL Aug 22 1930

20 UNDERTAKER J Lennon Bru

ADDRESS 1127 E Baltimore

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59954

129 E 59954

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Maryland Gen. Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Madison-Linden ST. 27-43 WARD)

2—FULL NAME Mrs Lena Porter

(a) RESIDENCE NO. 6416 Brook ave ST., Roslyn WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

If married, widowed, or divorced (or) WIFE of Mr Arthur J White

DATE OF BIRTH (month, day, and year) Sept 26, 1892

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	11	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Mr J Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER J Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Hospital records

(Address)

Filed ..., 19... Registrar

21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20, 1930.

17 I HEREBY CERTIFY, That I attended deceased from August 16, 1930, to August 20, 1930,

that I last saw h alive on August 20, 1930, and that death occurred, on the date stated above, at 2:15 m. S.T.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Chronic myocarditis

Uremia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What tests confirmed diagnosis? Clinical

(Signed) Robert H. Clements, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Aug. 23 1930

20 UNDERTAKER Fred'k Lassahn Sons

ADDRESS 5401 Belair Rd.

c.—1-30—M. & T.—250 Bks

E 59955

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59955

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST. 76-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Thomas.

BALTIMORE CITY HOSPITALS

(a) RESIDENCE NO. ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced (HUSBAND of or) WIFE of Mary Thomas

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Bennettsville S. C.

10 NAME OF FATHER Harris Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Elen Pierson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

Informant Records Dept. (Address) BALTIMORE CITY HOSPITALS

Filed 8 2 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1928, to August 19, 1930, that I last saw him alive on Aug. 19, 1930, and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic, with oedema.

(duration) 2 1/2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (not Mumps) Parotitis, acute (duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padgett, M. D.

8-21, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park, S C Bennettsville

DATE OF BURIAL 8/23 1930

20 UNDERTAKER Wilson Cook

ADDRESS 1217 St Paul St

8-16-29—L. F. S.—100 Blks.

E 59956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 59956

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 W Lombard ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Handley

(a) RESIDENCE NO. 1038 W Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married.

If married, widowed, or divorced
HUSBAND of (or) WIFE of Patrick Handley.

DATE OF BIRTH (month, day, and year) June 29-1862

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	1	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland.

10 NAME OF FATHER Patrick Barlow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Fight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

Informant Mr Patrick Handley

(Address) 1038 W Lombard St.

Filed 8-26 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/10/1930, to 8/21/30 19..., that I last saw h[illegible] alive on 8/21/30, 19 0 3?, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) enter Apoplexy 8/10/30

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Leonard J Levy, M. D.

8/24, 1930 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 8/25/1930

20 UNDERTAKER John J Cowan & Son.

ADDRESS 901 Hollins St.

21930 [illegible] Registrar

ec.—8-16-29—L. F. S.—100 Bks.

59957

E 59957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. .....

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Charles & 31 ST. 12-50 WARD)

2—FULL NAME Katherine Norris Powell

(a) RESIDENCE NO. Homewood Apts ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. 74 mos. 3 ds. 3 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Henry Powell

ATE OF BIRTH (month, day, and year) ~~Aug 21 1856~~ May 18 1856

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	& 3	3	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

IRTHPLACE (city or town) Baltimore
(State or country) Md

19 NAME OF FATHER Robert H Norris

11 BIRTHPLACE OF FATHER (city or town) Harford Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine A Young

13 BIRTHPLACE OF MOTHER (city or town) Harford Co
(State or country) Md

Informant Mrs. W. H. Wright

(Address) Homewood Apts

21930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21-1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to Aug 21, 1930,

that I last saw h alive on Aug 21, 1930

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral arterio Sclerosis

(duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) Standish McCleary, M. D.

19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park Cem

DATE OF BURIAL 8/29/1930

20 UNDERTAKER Henry W. Jenkins' Sons Co

ADDRESS Pennsylvania Ave. McCulloh.

M. & T.—100 B—50L

E 59958

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 59958

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No. Provident Hosp. WARD) 14-20

2-FULL NAME Jewellyn, Col

(a) RESIDENCE NO. 511 Mission St., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) Feb 14 - 1881

GE 47	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	7	

CCUPATION OF DECEASED
a) Trade, profession or particular kind of work Foreman
b) General nature of industry, business, or establishment in which employed (or employer) 086
c) Name of employer do

RTHPLACE (city or town) Martinsburg
State or country) Va

0 NAME OF FATHER Martin Jewellyn

1 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

2 MAIDEN NAME OF MOTHER Martha Green

3 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

nformant Jessie Jewellyn

(Address) 511 McCulloh

Filed 192

C. HAMPSON JONES, M. D.
Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Coroner at autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Coroner, M. D.

Aug 21st (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 25 - 30
UNDERTAKER	ADDRESS
Geo I. H. Gibson	1735 Druid Hill Ave

Aug 22 1930

c.—2-29-28—L. F. S.—500 Bks.

E 59959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1144 E 59959

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 1054 W. Fayette ST.) (18-76 WARD)

2—FULL NAME Daniel Lewers

(a) RESIDENCE NO. 1054 W. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 7/25/1926

AGE: Years [redacted] Months 9 Days 25 If LESS than 1 day, hrs. or min.

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

8 BIRTHPLACE (city or town) Baltimore City.
(State or country)

9 NAME OF FATHER Stephen M Lewers

10 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

11 MAIDEN NAME OF MOTHER Blanch Gardner

12 BIRTHPLACE OF MOTHER (city or town) Calvert Co Md
(State or country)

Informant Stephen M Lewers

Address 1054 W Fayette St.

Filed [illegible] 1930 H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 18th, 1930, to Aug 19th, 1930, that I last saw him alive on Aug 19th, 1930 and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) State Food and improper food

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no. What test confirmed diagnosis? Clinical Diagnosis

(Signed) J. L. Dunn, M. D.

8/20 1930 (Address) 522 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calary Cemty

DATE OF BURIAL: Aug 22 1930

20 UNDERTAKER: Walter B. Spriggs

ADDRESS: 159 W. Lanvale St.

Cor.—10-10-29—A Co.—100 Bks.

E 59960

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59960

CERTIFICATE OF DEATH

REGISTERED NO. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospitals St., 8-12 Ward)

2-FULL NAME Adolph Schuchardt

(a) RESIDENCE NO. 1022 Patterson Park Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Schuchardt

6 DATE OF BIRTH (month, day, and year) Feb 16 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63	6	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Mr Schuchardt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Prussia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mary Rennie
(Address) 4660 Park Rd

15 Filed ..... 19 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to true death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

S. 220 D.S. 16

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Sclerosis of arteries

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) James M Hanlon, M. D.

8/22 1930 (Address) 7002 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL 8/23 1930

20 UNDERTAKER William Cook — ADDRESS 127 St Paul

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 5996 1 — E 5996 1

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 26-36 Ward)

2-FULL NAME Mattie C. Mosley

(a) RESIDENCE NO. 6515 St. Helena Ave St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Cephus Mosley

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Va.

PARENTS

10 NAME OF FATHER — Melton

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Cephus Mosley
(Address) 6515 St. Helena Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

8-22-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia of Pregnancy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wegrue Talbot, M. D.

8/22 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	8/23 1930
20 UNDERTAKER W. M. Cook	ADDRESS 1317 E. Pratt St

ec.—1-12-23—M&T—500 Blks.

E 59962 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 59962

CERTIFICATE OF DEATH. 23

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 734 S. Regester St. (WARD) 4

2-FULL NAME John Fabiszak

(a) RESIDENCE NO. 734 S. Regester ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ida Fabiszak

DATE OF BIRTH (month, day, and year) Dec. 24, 1870

AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	59	7	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Balto. City.

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Joseph Fabiszak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant ~~Son~~ Daughter

(Address) 613 S. Bailey

Filed Aug 23 1930 CHARLTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1930.

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1930, to Aug. 20, 1930, that I last saw him alive on Aug. 20, 1930, and that death occurred, on the date stated above, at 1 00 A. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas J. Feinglos M. D.

8/30, 1930 (Address) 400 E. Biddle.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Aug 23 1930.

20 UNDERTAKER A W Gazewski ADDRESS 1930 Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

E. 59963

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 59963

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balto City Hospital St. 26-37 Ward)

2-FULL NAME Agnes Matulkas

(a) RESIDENCE NO. 530 S 32nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Ludwig Matulkas

6 DATE OF BIRTH (month, day, and year) [illegible] 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Simon Safran

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Vera Wiczulis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Alexander Matulkas
(Address) 518 S Regester St

15 Filed 2 2 1930 19 C. H. Hamilton Jones, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture L. R. Neck Femur Accident, Fall on Street Injury
(duration) yrs. mos 9 ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos 3 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

8-22-1930 (Address) 701 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See ceverse side foc additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug 23 1930
20 UNDERTAKER	ADDRESS
J. M. Zagurski	1920 Eastern Ave

ec.—1-30—M. & T.—250 Bks.

E 59964

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59964

CERTIFICATE OF DEATH.

× 49

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME William Hatfield

(a) RESIDENCE NO. Oman, W. Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3, ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 6 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deputy Sheriff

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country) W. Va

10 NAME OF FATHER Anderson Hatfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Lenia Hatfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

Informant JOHNS HOPKINS HOSP

(Address)

Filed 8 22 1930 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22-1930

17

I HEREBY CERTIFY, That I attended deceased from Aug 19, 1930, to Aug 22, 1930,

that I last saw h alive on Aug 22, 1930,

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - malignant

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ? Broncho-Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? West Va.

Did an operation precede death? Yes Date of 8-21-30

Was there an autopsy? Yes

What test confirmed diagnosis? - Operation

(Signed) Chas Briggs, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Logan, Logan County W. Va	Aug 22 1930
UNDERTAKER John O Mitchell & Son	ADDRESS 1900 Eutaw Place

Dec.—1-30—M. & T.—250 Bks.

239719
E 59965

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59965

CERTIFICATE OF DEATH.

+ 135

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Martin Oilar

(a) RESIDENCE No Russellville Penn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Feb-26-1852

AGE Years	Months	Days 26	If LESS than 1 day, hrs. or min.
78	5	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ind

10 NAME OF FATHER Dr Levi Oilar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Cath Van Brunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 22, 1930, that I last saw him alive on Aug 22, 1930, and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
Pulmonary Oedema

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis. Benign Prostatic Hypertrophy

yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) H. C. Smith M. D.

8-22, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL FRANKFORT, INDIANA

DATE OF BURIAL AUG 22, 30

20 UNDERTAKER Hughes-Jones Co

ADDRESS 4th & Broadway

C.—1-30—M. & T.—250 Bks

E 59966 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59966

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 519 S. Wolfe ST. (or WARD) 2-4

2-FULL NAME Louise Hammer

(a) RESIDENCE NO. 519 S. Wolfe ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John Hammer

DATE OF BIRTH (month, day, and year) Feb. 2nd 1864

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	6	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER George Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Ann ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant John Hammer

(Address) 519 S. Wolfe St.

Filed 2 1930 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20th/30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1930, to Aug 20, 1930, that I last saw h[illegible] alive on Aug 18, 1930 and that death occurred, on the date stated above, at 5 1/4 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chr. Myocarditis

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. cholecystitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) I. Gerst Zapp, M. D.

, 19 (Address) 413 S. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Aug. 23 1930

20 UNDERTAKER Lilly & Sons Inc. ADDRESS 403 S. Wolfe St.

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59967

E 59967

CERTIFICATE OF DEATH

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp (Ward) 23-31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wible

(a) RESIDENCE NO 7 W. Oslund St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10 1907

7 AGE Years 22 Months 9 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Geo. Wible

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eva Sneeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Next Kin

(Address)

Filed Aug 27 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd & 3rd degree burns over body

(Duration) yrs. mos. Caught

CONTRIBUTORY (Secondary) Electric wiring fire in elevator shaft

(Duration) yrs. mos.

18 Where was disease contracted? If not at place of death? Pelham St Ext

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) A. Gluck, M. D. Coroner

(Address) Aug 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crisfield Md

DATE OF BURIAL Aug 27 1930

20 UNDERTAKER John A Bradshaw

ADDRESS Crisfield Md

...ec.—1-30—M. & T.—250 Bks

E 59968 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59968

CERTIFICATE OF DEATH. 160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 4-7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Biankowski

(a) RESIDENCE NO. Montgomery Rd Howard County Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) February 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. (Ild)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Montgomery Rd Howard County.

10 NAME OF FATHER Joseph Biankowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Hospital Records.

(Address)

Filed 2-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1930, to August 19, 1930, that I last saw him alive on August 19, 1930, and that death occurred, on the date stated above, at 5.30-9 m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) G. Baron Hamilton M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cem. DATE OF BURIAL Aug 23 1930

20 UNDERTAKER Easton Son ADDRESS Edmondson City

Dec.—1-30—M. & T.—250 Bks.

Dr Schleider
3307 E Balto St

E 59969

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59969

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 38 S. East Ave ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Dann

(a) RESIDENCE NO. 38 S. East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of Louis Dann

DATE OF BIRTH (month, day, and year) May 4 1842

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
88		3	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Peter Lantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Lantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Elizabeth Burkhardt

(Address) 38 S East Ave

C. HAMPSON JONES, M. D. Registrar

19 Dat

21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to Aug 22, 1930,

that I last saw h Ev alive on Aug 22, 1930,

and that death occurred, on the date stated above, at 630 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gen Hosp

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Necropsy

(Signed) M. D.

19 (Address) 630 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Aug 24 1930
20 UNDERTAKER William Cook	ADDRESS 1217 N Eutaw

Thomas Stickels ✓

1-30 M A T 250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59970

E 59970

CERTIFICATE OF DEATH.

164

REGISTERED NO. 24-33

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Balto. City Hosp. ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stickles, Thomas

(a) RESIDENCE NO. 505 E. Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Widowed.

If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of

DATE OF BIRTH (month, day, and year) 8/15/44

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85	85	0	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) odd

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Clark Co. Va.

10 NAME OF FATHER Thomas Stickles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ely ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant (Address) Records Baltimore Hosp.

FILED 8 22 1930 H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 21, 1930, that I last saw h/s alive on Aug 21, 1930, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Senile Heart Disease

2

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Senile Psychosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Goldwater, M.D.

8/22 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester Va.

DATE OF BURIAL 8/20 1930

20 UNDERTAKER J. F. M. Cully

ADDRESS 130 E Fort.

ec.—1-30—M. & T.—250 Bks.

239978 E 59971 ✓ 143 E 59971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Conray

(a) RESIDENCE NO. 2317 Mc Elderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

If married, widowed, or divorced HUSBAND of or) WIFE of Daniel Conroy

DATE OF BIRTH (month, day, and year) Jan - 27 1896

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	7	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Duff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed 8-2 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-21-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1930, to Aug 21, 1930, that I last saw her alive on Aug 21, 1930, and that death occurred, on the date stated above, at 12-50 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Tubal pregnancy left with Exsanguination

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Tubal Pregnancy left

(duration) yrs. 2 1/2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Aug 20, 1930

Was there an autopsy? Yes Left salpingo oophorectomy

What test confirmed diagnosis? Autopsy

(Signed) H. L. Everett, M. D.

8/21, 1930 (Address) The Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hartsdale Smith Chapel Church Son. DATE OF BURIAL Aug 23 1930

20 UNDERTAKER Wm. E. Miller & Son ADDRESS 2334 Jefferson St.

Cor.—10-10-29—A Co.—100 Blks.

E 59972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59972

REGISTERED NO. 179

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital. 9-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph J. Jaecksch.

(a) RESIDENCE NO. 2188 Jefferson St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, ~~widowed, or divorced~~
HUSBAND of ~~XXXXXXXXXX~~ Mamie Jaecksch.

6 DATE OF BIRTH (month, day, and year) January 17, 1868.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	62	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Weigher Grain Elevator.
(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Theodore Jaecksch.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Riepe.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Mamie Jaecksch. (wife)
(Address) 2188 Jefferson St.

15 Filed Aug 25 1930 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burns about the face and body due to an explosion in B. & O. R. R. Grain Elevator. Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fort Covington.
Did an operation precede death? No. Date of Aug. 20, 1930
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto C. Steinhardt, M. D.
8/22 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer. DATE OF BURIAL Aug 25 1930

20 UNDERTAKER Leo G. Leook ADDRESS 1723 Park Ave

ec.—2-29-28—L. P. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59973

CERTIFICATE OF DEATH

E 59973

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. Md. General Hospital ST. (If not in hospital give WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Artie J. Sowers

(a) RESIDENCE NO. 1716 Crystal Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
[redacted] of Dora Sowers

DATE OF BIRTH (month, day, and year) Mar 29, 1877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rammer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Calvin Sowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary Deets

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

Informant Hospital records

(Address)

Filed ..... 19 ..... Registrar

C. BAMPSON JONES, M. D.

3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-21-30

17

I HEREBY CERTIFY, That I attended deceased from 8-5, 1930, to 8-21, 1930,

that I last saw h[illegible] alive on 8-21 — 1930

and that death occurred, on the date stated above, at 4 35 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Pylorus ulcer - (Ruptured & adherent to head of pancreas) - (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of heart (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 8-16-30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Robert F. Chenoweth, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL 8/25/30 19

20 UNDERTAKER Geo. C. Pulp & Son

ADDRESS 1135 Hanover

ec.—1-30—M. & T.—250 Bks.

E 59974 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59974

CERTIFICATE OF DEATH. † 135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Harriet Tubman ST. 4-30 WARD)

2-FULL NAME George F Faust.

(a) RESIDENCE NO. 11 Montrose Ave. Catonsville WARD Maryland

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of or) WIFE of: Anna Faust.

DATE OF BIRTH (month, day, and year): Mar. 28, 1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	4	24 23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Hamilton Oa

10 NAME OF FATHER: Henry Faust

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Kuntz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant (Address): Mrs Anna Faust 11 Montrose Ave

Filed 23 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/21/30.

17 I HEREBY CERTIFY, That I attended deceased from 7/30, 19 30, to 8/21, 19 30,

that I last saw h[illegible] alive on 8/21, 19 30,

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Prostatic obstruction

(duration) uncertain yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clin & lab

(Signed) Henry D. Mccaul M. D.

, 19 (Address) Univ. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Aug 25, 30

20 UNDERTAKER: Wm Fleckner Sons

ADDRESS: Norfolk Va

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59975

CERTIFICATE OF DEATH

18 E 012 59975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH U.Md.E.R.Grain Elevator.

City of Baltimore: (No. Port Covington. St., 16-69 Ward)

2-FULL NAME Carl E.Hamill.

(a) RESIDENCE NO. 2708 Edmondson Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~
HUSBAND of (or) WIFE of Daisy E.Hamill.

6 DATE OF BIRTH (month, day, and year) October, 13, 1878.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	51	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Weigher Grain Elevator.
(b) General nature of industry, business, or establishment in which employed (or employer) U.Md.E.R.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles E.Hamill.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Bellner.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Daisy E.Hamill.(wife.
(Address) 2708 Edmondson Ave.

15 Filed ..... 19 ..... C. HAMPSON JONES, M.D.
Registrar.
AUG 23 1930
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed under a falling wall due to an explosion in U.Md.E.R.Grain. Elevator. Occidental Death.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Reinhardt, M. D.

8/22 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 8/23 1930

20 UNDERTAKER Eugene Finley Jr. Funeral Parlors

ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 59976 HEALTH DEPARTMENT—CITY OF BALTIMORE 103 E 59976

CERTIFICATE OF DEATH.

1888

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1309 Filmore St. 15-22 (WARD)

2-FULL NAME Annie Woodland

(a) RESIDENCE NO. 1309 Filmore ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 20-1864

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	6		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Alex Jones

(Address) 1309 E. Filmore St

Filed AUG 23 1930 J. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/26 1930 to 8/20 1930

that I last saw h[illegible] alive on 8/20 1930

and that death occurred, on the date stated above, at 2:15 A m

The CAUSE OF DEATH was as follows:

Ac Colitis (2 wks)

Broken leg (June 26th)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj. Lee Ellis, M. D.

8/21 1930 (Address) 2140 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Aug 23-30

20 UNDERTAKER: Geo. P. A. Gibson

ADDRESS: 1736 Druid Hill Ave

-30—M. & T.—100 B—50L

E 59977

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59977

CERTIFICATE OF DEATH

197

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Enroute

CITY OF BALTIMORE: (No. Hopkins Hospital 6-9 WARD)

2-FULL NAME Lucindia Louise Gray

(a) RESIDENCE NO 1 S N. Dallas ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry Gray

6 DATE OF BIRTH (month, day, and year) April 26/1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	3	25 24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James Louise

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Caroline, Va.

12 MAIDEN NAME OF MOTHER Annie Garrett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) A. A. Co., Md.

14 Informant James Louise (father)
(Address) 1704 Milliman St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

31930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20-30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage in chest-Pistol shot wounds --Homicide

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) J. S. Wolman, M. D.
Coroner

8/22/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL aug 25 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59978

CERTIFICATE OF DEATH.

E 59978

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 612 N. Arlington Ave. (St.) (Ward) 16-M

2-FULL NAME Laurence P. Gilmer (Gilmore)

(a) RESIDENCE NO. 612 N. Arlington WARD C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Willie B. Gilmor

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 37; Months; Days; If LESS than 1 day, hrs. or min.: 3 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Not known

9 BIRTHPLACE (City or town) (State or country): So. Carolina Co. Not known

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

PARENTS

14 Informant: Celia Phillips

(Address): 612 N. Arlington Ave.

15 AUG 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 20, 19 30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 19 30, to Aug. 20, 19 30, that I last saw him alive on Aug. 20, 19 30, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) About yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia (duration) 1 yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?: —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. Lisbon Shelton M. D.

8/3/1930 (Address) 1203 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Aug 23, 1930

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 32 Schroeder

Cor.—10-10-29—A Co.—100 Bks.

E 59979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1932 E 39979

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Pier 2 Pratt St. St. 17-24 Ward)

2-FULL NAME James Wilson

(a) RESIDENCE NO. 1007 Penna. Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Ja. Wilson

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Hannia Tyler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant J. Wilson
(Address) Va. Hospital Sparrows Point

Filed ..., 193 ... Registrar

3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18. 1932

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned accidental
Slipped off of board.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. T. Reny, M. D.

Aug 22, 1932 (Address) 1039 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newport News Va.	Aug 23. 1930
20 UNDERTAKER	ADDRESS 322
Mrs Katie R. Williams	4 Schroeder

Spec.—1-30—M. & T.—250 Bks

E 59980 HEALTH DEPARTMENT—CITY OF BALTIMORE 94-661 E 59980

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 18-24 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Frank C. Kruchiniski

(a) RESIDENCE No. 848½ W. Lombard St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Kruchiniski

7 DATE OF BIRTH (month, day, and year) 1888 ?

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42 ?				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

8 BIRTHPLACE (city or town) Unknown

(State or country) Poland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

Informant Records of

(Address) Baltimore City Hospitals

Filed 3 1930 19 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21, 1930.

17 I HEREBY CERTIFY, That I attended deceased from 6/4/30, 19 , to 8/21, 19 30.

that I last saw him alive on 8/21, 19 30.

and that death occurred, on the date stated above, at 1:50 A.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum.

more than 3 yrs. mos ds.

(duration)

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

8-21, 19 30 (Address) Baltimore City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL (August 25 1930)

20 UNDERTAKER Chas. R. Kruchowskas ADDRESS 637 S. Paca St

30—M. & T.—100 B—50L

E 5998I

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5998I

CERTIFICATE OF DEATH

REGISTERED NO. 25-72 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank L. Pierson.

(a) RESIDENCE NO. 1901 Eastern Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (1901 Eastern Ave.) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Huckster
(b) General nature of industry, business, or establishment in which employed (or employer): 045
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Jas Pierson

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Nancy E. Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Mrs Cummings

(Address): 1901 Eastern

15 AUG 3 1930 19 27

Filed: [illegible]

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 21st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) H. Schenck Jones, M. D. Coroner

Aug 21st, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: Aug 22 1930

20 UNDERTAKER: Edward Foeckler

ADDRESS: 2359 Wash Blvd

Spec.—8-16-29—L. F. S.—100 Bks.

E 59982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 ✓

E 59982

REGISTERED NO. 24154

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5728 Ridgedale Road ST. Washington WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel W. Powell

(a) RESIDENCE NO. 5728 Ridgedale Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 9 mos. 29 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M. Reese

DATE OF BIRTH (month, day, and year) Oct. 23, 1867

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	9	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Robert Garrett Co.

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER John Powell

11 BIRTHPLACE OF FATHER (city or town) Wales
(State or country)

12 MAIDEN NAME OF MOTHER Hannah Charles

13 BIRTHPLACE OF MOTHER (city or town) Wales
(State or country)

Informant Mrs. Ida M. Powell

(Address) 5728 Ridgedale Road

Filed AUG 24 1930 19 C. HAMPSON REES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1930

17 I HEREBY CERTIFY, That I attended deceased from October 31, 1929, to Aug 22, 1930, that I last saw h[illegible] alive on Aug 22, 1930 and that death occurred, on the date stated above, at 11.15 a.m. Standard

The CAUSE OF DEATH* was as follows:

Carcinoma [illegible] and [illegible] stomach

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Metastasis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 5th 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. V. Castagna, M. D.

19 (Address) York Rd & Shenton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: 8/25 19 30

20 UNDERTAKER: Kenny & Meads and Son

ADDRESS: 805 N. Calvert

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59983 E. 59983

CERTIFICATE OF DEATH.

118 H-24

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. Bldg ST., ~~(HOSPITAL OR WARD)~~

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary E. Smyser

(a) RESIDENCE NO. Albion Hotel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of Jas a Mr. Smyser

DATE OF BIRTH (month, day, and year) 1864

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) not employed

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Records

(Address)

C. HAMPSON JONES, M. D.

Filed 8 4 1930 19 per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23-30

17 I HEREBY CERTIFY, That I attended deceased from 8-12-30, 1930, to 8-23, 1930, that I last saw her alive on Aug 23, 1930, and that death occurred, on the date stated above, at 1:05 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos 13 ds

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Church Home & Inf

Did an operation precede death? yes Date of 8-20-30

Was there an autopsy? yes x-ray, operation, autopsy

What test confirmed diagnosis?

(Signed) A. E. Hubbard, M. D.

19 (Address) 707 Cornwall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Aug 25 1930

20 UNDERTAKER Henry W. Mearsdon

ADDRESS 805 N. Calvert St.

1-30—M. & T.—100 B—50L

E 59984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 59984

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3103 Erdman Ave., ST., 8-45 WARD)

2-FULL NAME Louis Stallmann

(a) RESIDENCE NO 3103 Erdman Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The late Barbara Stallmann

6 DATE OF BIRTH (month, day, and year) Oct.-31-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	9	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gardener at home
(b) General nature of industry, business, or establishment in which employed (or employer) n/a
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Stallmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Catherine Hetterick
(Address) No. 3103 Erdman Ave.

15 Filed 8-4 1930 C. Harper Jones M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocarditis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [signature] Coroner, M. D.

8/24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

20 UNDERTAKER Henry Hoecks Sons Inc

DATE OF BURIAL Aug 25 1930

ADDRESS 134 E Eager St

pec.—1-30—M. & T.—250 Bks.

C 59985

HEALTH DEPARTMENT—CITY OF BALTIMORE

C 59985

CERTIFICATE OF DEATH.

REGISTERED NO. 1888

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 22-24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dodyn -

(a) RESIDENCE NO. Cor. Carroll and Parkin ST., 846 Carroll St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced (HUSBAND) of (or) WIFE of Single

DATE OF BIRTH (month, day, and year) Sept 8 1910

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	19	11	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Operator

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer Bartlett Hayward Co

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER William F Cannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary J. Elmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant William F Cannon

(Address) 846 Carroll St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1930 -

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1930, to Aug 22, 1930,

that I last saw him alive on Aug 22, 1930,

and that death occurred, on the date stated above, at 9:55 P. m.

The CAUSE OF DEATH* was as follows:

fractured skull - (Acc)

Accidental Death

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? On street -

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) George H. Yeager M. D.

, 19 (Address) University Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL Aug 26 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

O. H. JONES, M. D.

pec.—1-30—M. & T.—250 Bks

Entwistle

59936 HEALTH DEPARTMENT—CITY OF BALTIMORE 14 E 59936

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Sinai Memorial Hospital

CITY OF BALTIMORE: (No. 2619 Barclay St. 17-50 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Entwistle

(a) RESIDENCE NO. 2619 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of James Entwistle

DATE OF BIRTH (month, day, and year) Sept. 17, 1866

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER William Edmondson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sara Fierhurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Hospital records

(Address)

Filed Aug 24 1930 19 H. M. Fox JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11th, 1930, to Aug. 23, 1930, that I last saw her alive on Aug. 23rd, 1930, and that death occurred, on the date stated above, at 1:40 P. M. Day light time

The CAUSE OF DEATH* was as follows:

Operation (Watkins interposition) relaxed vaginal outlet, cystocele & rectocele

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary thrombosis?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? yes Date of Aug. 16th

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Ralph G Hills M. D.

, 19 (Address) Sinai Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 8/26/1930

20 UNDERTAKER Wm Cook 1217 St Paul St

ADDRESS

pec.—1-30—M. & T.—250 Bks.

59987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 59987

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3453 Cottage Ave. ST. 15-58 WARD)

2-FULL NAME Della Applestein

(a) RESIDENCE NO. 3453 Cottage Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of or) WIFE of: Isaac Applestein

DATE OF BIRTH (month, day, and year)

AGE: Years 83; Months; Days; If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: J. Lewis

(Address): 1434 E Baltimore St

Filed AUG 25 1930

C. Hilton Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22-30

17 I HEREBY CERTIFY, That I attended deceased from July-14-, 1930, to Aug-22-, 1930, that I last saw her alive on Aug-22-, 1930, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Myo-Cardial Insufficiency.

attent 10-yrs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Heart-block

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

8/23-1930 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run

DATE OF BURIAL: 8-24-1930

20 UNDERTAKER: Jack Lewis, 1431

ADDRESS: E Balto St

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59988

CERTIFICATE OF DEATH.

100 001 E 59988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 406 S Caroline ST., 3-4 (WARD)

2-FULL NAME Addie Brown

(a) RESIDENCE NO. 4060 Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Matthews Brown

DATE OF BIRTH (month, day, and year) 1891

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia.

10 NAME OF FATHER Washington Sales

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Hill.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Matthews Brown

(Address) 4016 S. Caroline St

Filed JUL 24 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 22, 1930.

that I last saw him alive on July 22, 1930,

and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis.

Secondary Pneumonia

(duration) yrs. mos 2 ds.

Terminal CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Bernard Harris, M. D.

7/23/30 19 (Address) 3 E S Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md Surrey Co Va

DATE OF BURIAL July 24 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Eastman St

[illegible] JONES, M. D.

pec.—1-30—M. & T.—250 Bks.

E 59989 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59989

CERTIFICATE OF DEATH. X 101-001

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Good Shepherd Hospital ST., 28-71 WARD

2-FULL NAME Estella Blackwell.

(a) RESIDENCE NO. Spidmore A.A.Co. md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

If married, widowed, or divorced HUSBAND) of or) WIFE of Willie Blackwell.

DATE OF BIRTH (month, day, and year) Mar 26, 1883

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	4	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) A.A. Co. Md.

10 NAME OF FATHER Zick Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co. Md.

12 MAIDEN NAME OF MOTHER Louie Colbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A. Co Md

Informant Lilly Fountain

(Address) 1007 Edmondson Ave

Filed 4 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 18th, 1930, to Aug 20, 1930, that I last saw h[illegible] alive on Aug 19th, 1930, and that death occurred, on the date stated above, at 6A. m.

The CAUSE OF DEATH* was as follows:

Lobar - Pneumonia

(duration) yrs. mos 5 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical.

(Signed) Harry F. Brown, M. D.

8/20, 1930 (Address) 1916 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dross Neck Cem DATE OF BURIAL Aug 24, 30

20 UNDERTAKER Lennie L. Hensley ADDRESS 3 Bell

pec.—1-30—M. & T.—250 Bks

59990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 59990

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST. 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Curtis Eckels

(a) RESIDENCE NO. 3114 Gibbons Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Henry Eckels

DATE OF BIRTH (month, day, and year) Apr. 3-1874

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	4	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Frederick Freimann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Gephart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Henry Eckels

(Address) 3114 Gibbons Ave

Filed 4 1930 G. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-13, 1930, to 8-22, 1930, 19 ,

that I last saw her alive on 8-22, 1930,

and that death occurred, on the date stated above, at 8:45 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Partial collapse Rt lung

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Pathologist findings (Gross)

(Signed) F. M. Baumgardner, M. D.

, 19 (Address) Mercy Hospital Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Aug 25 1930

20 UNDERTAKER Wm. A. Black — ADDRESS 927 N. Broadway

Rec. 2-29-28—L. F. S.—500 Blks.

E 59991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-002 V

E 59991

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Annapolis Road ST. 25-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George F. Marks

(a) RESIDENCE NO. 2322 Annapolis Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) March 18, 1926

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	5	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER George F. Marks

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ruth A. Kraft

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Mrs. George Marks

(Address) 2322 Annapolis Road

Filed Aug. 25 1930 C. HARRIS JONES, M. D. Registrar

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from aug 22 1930 to aug 22 1930

that I last saw him alive on aug 22 1930

and that death occurred, on the date stated above, at 5.55 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

acute Staphylococcus non Suppurative (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas McKeffer, M. D.

Aug 23 1930 (Address) 2454 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug. 25 1930

20 UNDERTAKER Jos B. Cook

ADDRESS 1003 West Baltimore St

Cor—12-9-25—A Co.—200 Bks.

Isaac T. Jones. 90

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59992

REGISTERED NO. E 59992

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1182 E Baltimore St. 12-51 Ward)

2-FULL NAME Isaac T. Jones

(a) RESIDENCE NO. 2616 N. Edmondson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 56 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Bros
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Jones

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Pemberton

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: T. J. Jones
(Address): Norfolk Va

15 Filed ... 19 ... JONES M D
Registrar

AUG 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 23rd 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Interval (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Heart Suddenly

(duration) ... yrs. ... mos. ... ds.

Aug 24 (Signed) ... M. D.
, 19 31 (Coroner)
(Address) 1659 Brown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old Point Va. Date of Burial Aug 24 1930

20 UNDERTAKER: Hughes & Stone Inc ADDRESS Fort Mon

Cor.—10-10-29—A Co.—100 Bks.

E 59993

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59993

CERTIFICATE OF DEATH

179

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St. or Ward)

2-FULL NAME Joseph G. Doemling.

(a) RESIDENCE NO. 818 N. Bouldin St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 1 mns. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of Bessie Doemling.

6 DATE OF BIRTH (month, day, and year) July 21 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	88	1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) B. Md. R. R. Co.
(c) Name of employer Grain Elevator.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Andrew Doemling.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Foster.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Bessie Doemling. (wife)
(Address) 818 N. Bouldin St.

15 Filed G 24 1930 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burns about the face and body due to an explosion in B. Md. R. R. Grain Elevator. Occidental Death.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Fort Covington, N.Y. August 20, 1930

Did an operation precede death? No. Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Reinhardt, M. D.

8/28, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Hill Cem.

DATE OF BURIAL 8/25 1930

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 59994 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59994

CERTIFICATE OF DEATH

REGISTERED NO. 90 27

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Bon Secours Hospital ST., (WARD)

2—FULL NAME William Carroll

(a) RESIDENCE NO. Glen Arm Md ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Jennie Carroll

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work) none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Jennie Carroll

(Address) Glenarm Md

Filed Aug 24 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 24, 1930, that I last saw h~~im~~ alive on Aug 24, 1930, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Generalized

Chronic Myocarditis -

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm A Hilleshe, M. D

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cem. Longview Md

DATE OF BURIAL Aug 27 1930

20 UNDERTAKER Clarence E. Arthur

ADDRESS Fork Md

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59995 ✓ E 59996

+188-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Conway & Davis Memorial Hosp. ST. 17-44 WARD)

CITY OF BALTIMORE, (NO. Baltimore County)

2-FULL NAME Clara Jane Freeland.

(a) RESIDENCE NO. Between Brooklyn ville & Rockland (Near Brooklandville Md. Balto. Co.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Carl C. Freeland.

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69 years of age			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 87

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer State Hgh. Way

BIRTHPLACE (city or town) (State or country) Baltimore, County.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Ensor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant ~~Self~~ S.E. Fichter

(Address) 6501 - Wetherburn - Brooklandville Md.

15 Filed AUG 24 1930 19 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24, 1930.

17 I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....

that I last saw h.... alive on ....., 19....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows:

Multiple fractures, & compound fractures & Cranium (Traffic accident) Collision which they were riding was struck by motor truck

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) auto-truck accident

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Rockland Md

Did an operation precede death? no Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) Dr Samuel McLean M. D.

Aug 24, 1930 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grace M. E. Cem.

DATE OF BURIAL Aug 27 1930

ADDRESS Towson

20 UNDERTAKER Tolley Burns Sons

Spec.—1-30—M. & T.—250 Blks Caleb C. Freeland

E. 59996

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 59996

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Runway to Union Memorial Hosp. 188-001

CITY OF BALTIMORE: (No. ~~Baltimore County.~~ 47-46 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caleb C Freeland. (Res Brooklandville Md. Balto Co.

(a) RESIDENCE NO. Baltimore County. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	married.

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Clara Jane Freeland.

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Seventy years.			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer State Highways

BIRTHPLACE (city or town) (State or country) unknown. unknown.

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant S. E. Fiddler.

(Address) 6501 Wilkins Ave. Govanstown Md.

15 Filed Aug 27 1930 . 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24, 1930.

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Compound fracture of cranium (Traumatic)

Auto in which they were riding was struck & overturned

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rockland Md Balto Co

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel McClenahan M. D.

Aug 27 1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grace M. P. Cem. DATE OF BURIAL Aug 27 1930

UNDERTAKER J. Kelly Burns Sons ADDRESS Towson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59997

CERTIFICATE OF DEATH.

31 E 59997

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 59997
1-PLACE OF DEATH

CITY OF BALTIMORE: NO 314 Myrtle ave ST. 4-76 WARD)

2-FULL NAME Laurence Coleman

(a) RESIDENCE. NO 314 Myrtle ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: C

6 DATE OF BIRTH (month, day, and year): Jan 9 1915

7 AGE: Years 11 Months 7 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: C
(b) General nature of industry, business, or establishment in which employed (or employer): C
(c) Name of employer: C

9 BIRTHPLACE (city or town) (State or country): St Michaels Talbot Co Md.

PARENTS

10 NAME OF FATHER: Laurence W Coleman
11 BIRTHPLACE OF FATHER (city or town) (State or country): Mt Wash Balto Co Md
12 MAIDEN NAME OF MOTHER: Catherine Phillips
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pocomoke City Worcester Co Md

14 Informant (Address): Edward Coleman 314 Myrtle ave

Filed AUG 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 1930, to Aug 23 1930, that I last saw him alive on Aug 21 1930, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
I do not know
(duration) yrs. mos.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

Aug 23 1930 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary — DATE OF BURIAL: Aug 26 1930

20 UNDERTAKER: John H. Frades — ADDRESS 1027 Edmondson Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 59998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 59998

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1826 Aiken St. (St.) 16-29 (WARD)

2—FULL NAME John Bridges

(a) RESIDENCE NO. 1211 W. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

If married, widowed, or divorced: HUSBAND of (or) WIFE of Helen Bridges

DATE OF BIRTH (month, day, and year) April 18, 1861

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

BIRTHPLACE (city or town) (State or country): Emmanstown Md

10 NAME OF FATHER: Robert Bridges

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Margaretta Akers

12 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: John E. Bridges Jr.
(Address): 1826 Aiken St.

15 Filed: AUG 25 1930 JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1930 to August 22, 1930

that I last saw him alive on August 22, 1930

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

about 1 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel B Wolfe M. D.

Aug 25. 1930 (Address) 1331 E. Monument Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: aug 25 1930

20 UNDERTAKER: Cosby & Co. Inc. — ADDRESS: 1221 W Fayette Ave

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59999

E 59999

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1.-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. 36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2.-FULL NAME Baby Joseph Ritz

(a) RESIDENCE NO. 6545 Parnell ave ST. St. Helena WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of or) WIFE of none

DATE OF BIRTH (month, day, and year) 7/7/30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5 wks.		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph M. Ritz Jr.

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Ethel Greene

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Martinsburg W. Va.

14 Informant Joseph M. Ritz Sr.

(Address) 6545 Parnell Ave St. Helena

15 [illegible] JONES, M. D.

Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1930 19 to Aug 24, 1930 19.

that I last saw him alive on Aug 24-1930 19

and that death occurred, on the date stated above, at 4.50 m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Malnutrition ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys findings + Lab. work

(Signed) H. Holden Baker M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rose Hill-Hagerstown Md. DATE OF BURIAL aug. 26 1930

20 UNDERTAKER Curley & Co. Inc. ADDRESS 1021 N. Fayette

Spec.—1-30—M. & T.—250 Bks

E. 60000 E. 60000 E. 60000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708. Huron St ST. 25-73 WARD)

2-FULL NAME Edward, A. Kreczmer

(a) RESIDENCE NO. 2708. Huron St ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 25-1911

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	3	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At. Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John E. Kreczmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Atlanta Ga

12 MAIDEN NAME OF MOTHER Agnes E. Monka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore.

14 Informant John. E. Kreczmer

(Address) 2708 Huron St

19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 30

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 23, 1930, that I last saw h alive on 19, and that death occurred, on the date stated above, at 8.30 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, heart disease

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Raymond Williams M. D.

2-, 1930 (Address) 2[illegible] Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL 8/26 1930

20 UNDERTAKER William Fialkowski

ADDRESS 1618. Eastern Ave.

E 60001 HEALTH DEPARTMENT—CITY OF BALTIMORE 112 E 60001

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 W. Lexington ST. 18-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Pinkney

(a) RESIDENCE NO. 823 W. Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Father of the Death.

(Address)

Filed AUG 25 1930 H. LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to August 22, 1930, that I last saw h. alive on August 21, 1930 and that death occurred, on the date stated above, at about 4 p. m.

The CAUSE OF DEATH* was as follows:

Cardio spasm meaning functional obstruction of cardiac end of stomach

Diaphragmatic origin.

Premature senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry C. Smith, M. D.

, 19 (Address) 4627 Reisterstown Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Aug. 25, 1930

20 UNDERTAKER: Mrs Katie R. Williams

ADDRESS 3221 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks

E 60002

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60002

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. 14-20 ST.) (WARD)

2-FULL NAME Charles Johnson

(a) RESIDENCE NO. 1520 Shields Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Oct 1 - 1859(?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71(?)	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Gen'l

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1929 to Aug. 23, 1930, that I last saw h. alive on Aug. 23, 1930, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uterus Myoma unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Foret, M. D.

(Address) 8-24 1930 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Aug 27 1930

20 UNDERTAKER Wm. H. Chase & Son ADDRESS 1400 Madison

REGISTERED AUG 27 1930 WM. H. JONES, M. D. Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

E.60003 · HEALTH DEPARTMENT—CITY OF BALTIMORE E 60003

CERTIFICATE OF DEATH

46

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2005 E. 30th ST. 4th WARD)

2—FULL NAME Emilie S. Hilson

(a) RESIDENCE NO. 2005 E. 30th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Leonard J. Hilson

6 DATE OF BIRTH (month, day, and year) Aug. 26-1866

7 AGE — Years 63 | Months 11 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baden Germany

PARENTS

10 NAME OF FATHER August S. Seyfried

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baden Germany

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baden Germany

14 Informant Leonard Hilson

(Address) 2005 E 30th St

15 Filed 1930 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 28th, 1929, to Aug 21st, 1930, that I last saw h[illegible] alive on August 21st, 1930 Standard time and that death occurred, on the date stated above, at 4 a.m. Aug 22nd/30

The CAUSE OF DEATH* was as follows:

Uraemia —

(duration) yrs. mos. 8 ds. —

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Autopsy Date of 8/12/30

Was there an autopsy? No. —

What test confirmed diagnosis? Clinical Symptoms

(Signed) Hugh W. Brandt M. D.

, 19 (Address) 16 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorsey Cem

DATE OF BURIAL 8/15 1930

20 UNDERTAKER J. F. Daly & Sons

ADDRESS 131 N. Eden

Spec.—1-30—M. & T.—250 Bks.

Dr Magnire, 14 E Read

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60004

CERTIFICATE OF DEATH.

46

E 60004

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 245 (ST.) Arch Street (WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jannie Kirkley

(a) RESIDENCE NO. 245 (ST.) Arch (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Charles Kirkley

6 DATE OF BIRTH (month, day, and year): Aug 27, 1867

7 AGE: Years 62 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Francis Morrow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Hilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant: Charles Placidy (Address) 245 Arch St

15 Filed ..... 19 ..... Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1928, to Aug. 23, 1930, that I last saw h[illegible] alive on Aug. 23d, 1930, and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma. Uteri

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 11-1930

Did an operation precede death? yes Date of St Agnes Hospital

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Chas H. Magnire, M. D.

8/24 1930 (Address) 14 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Aug 26 1930

20 UNDERTAKER: Williams Cook — ADDRESS: 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 60005

E 60005

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Gen Hospital (or) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Wilson

(a) RESIDENCE NO. 816 North Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Anna Wilson.

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Apprx 50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rowland Sch- Brunswick & Co.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Mosd Wilson.

11 BIRTHPLACE OF FATHER (city or town) Brunswick Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie Wilson.

13 BIRTHPLACE OF MOTHER (city or town) Brunswick Co. (State or country) Maryland.

14 Informant Maryland Gen. Hospital (Address)

15 [illegible] 25 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-22-30

17 I HEREBY CERTIFY, That I attended deceased from 8-20-, 1930, to 8-22, 1930, that I last saw him alive on 8-22-, 1930, and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous appendicitis

Generalized Peritonitis

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-20-30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Robert V. Clements, M. D.

. 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Aug 25 1930

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pennsylvania Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60006

E 60006

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Riggs Ave. ST., 1622 WARD)

2-FULL NAME Louise Heim

(a) RESIDENCE NO. 1810 Riggs Ave. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER August Heim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Emma Heim

(Address) 1810 Riggs Ave.

15 Filed 2 5 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 18th, 1930, to Aug 24, 1930, that I last saw h[er] alive on Aug 23, 1930, and that death occurred, on the date stated above, at 9.00 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) E. Hollis Henning M. D.

8/24 1930 (Address) 2000 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug. 26 1930

20 UNDERTAKER Joseph D Cook

ADDRESS 1003 West Baltimore St

H. HANSON JONES, M. D.

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

60007

HEALTH DEPARTMENT—CITY OF BALTIMORE

60007

CERTIFICATE OF DEATH

REGISTERED NO. 166

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Harriet Memorial Hospital St., Ward

2-FULL NAME Mrs. Edith Smith

(a) RESIDENCE NO. 522-N-33rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph H. Smith

6 DATE OF BIRTH (month, day, and year) Sept 30 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	32	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co
(State or country) Md

PARENTS

10 NAME OF FATHER Harry Dumphry

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Blanch Bailey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mary E. Smith
(Address) Roland Ave

15 Filed JUL 25 1930 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:
Cerebral Hemorrhage
Probably Spontaneous
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Morrison, M. D.

July 24 1930 (Address) 3622 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	July 28 1930
20 UNDERTAKER	ADDRESS
Dept 10 Cook	403 W Lafayette

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 60008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 60008

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 425 Myrtle ave ST. 17-26 (WARD)

2-FULL NAME Christiana Hawkins

(a) RESIDENCE NO. 425 Myrtle ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Woodward
(Address) 514 Lehmder St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25/30

17 I HEREBY CERTIFY, That I attended deceased from May 25th 1930 to Aug 24th 1930.
that I last saw her alive on Aug 23 1930,
and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Exsanguination (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of /

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustav Oldman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 8-26 1930

ADDRESS 916 Oak St

20 UNDERTAKER Dennis Easton

25 1930 H. M. [illegible] JONES, M. D. Registrar

1-30—M. & T.—100 B—50L

E 60009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

112

E 60009

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 569 N Bradde) (Ward) 7-24

2-FULL NAME John W. Smith

(a) RESIDENCE NO 569 N Bradde St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1895-Feb

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter 07
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Lucy Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Smith

(Address) 569 Bradde

15 Filed AUG 25 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Error of diet

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Allen A. Regan, M. D. Coroner

(Address) 1 E. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 8-26 1930

20 UNDERTAKER Dent Carter

ADDRESS 916 Druid

FROM is very important. See instructions on back of certificate.

Spec. 1-30 M. & T. 250 Blks.

E 60010 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 122 — E 60010

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 Ashland Ave, ~~St.~~ 10-14 WARD)

2-FULL NAME Asburn Reeders

(a) RESIDENCE No. 823 Ashland Ave ~~St.~~ WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leona Reeders

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Thomas (State or country) West Indies

PARENTS

10 NAME OF FATHER John Reeders

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies

14 Informant Leona Reeders
(Address) 823 Ashland Ave

15 Filed 8 25 1930 19 JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/23/30

17 I HEREBY CERTIFY, That I attended deceased from 6/1, 1930, to 8/23, 1930
that I last saw ~~him~~ alive on 8/23, 1930
and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Cirrhosis of Liver and Myocarditis

(duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) Hard-work

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. O. Kahlke M. D.

8/25, 1930 (Address) 924 Wilgate

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem.	8-25 1930

20 UNDERTAKER Byron Knight ADDRESS 1218 McCulloh St

Spec.—1-30—M. & T.—250 Bks.

E 60011 HEALTH DEPARTMENT—CITY OF BALTIMORE 114 E 60011

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospitals ST., 7-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Kohler

(a) RESIDENCE NO. 2122 Jefferson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George F. Kohler

6 DATE OF BIRTH (month, day, and year): Mar 24 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Patrick Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Sweeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Margaret King

(Address) 206 Lafayette Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-23-30

17 I HEREBY CERTIFY, That I attended deceased from 8-21, 19 30, to 8-23, 19 30,

that I last saw h[illegible] alive on 8-23, 19 30,

and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Enteritis and Ulcerative Colitis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and Autopsy

(Signed) Lester E. Lewis M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Aug. 26 19 30

20 UNDERTAKER: Mrs. E. Miller D. Son

ADDRESS 2334 Jefferson St.

25 1930 C. WILSON JONES, M. D.

Spec.—7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 60012
REGISTERED NO.

E 60012
1-PLACE OF DEATH

City of BALTIMORE: (No. 436 N. Register St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mitchell

(a) RESIDENCE NO. 436 N. Register St. Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Color	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) May 24/1915

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	15	yr 3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) Farmville,
(State or country) Virginia

PARENTS

10 NAME OF FATHER John Mitchell
11 BIRTHPLACE OF FATHER (City or town) Farmville
(State or country) Virginia
12 MAIDEN NAME OF MOTHER Carrie Ross
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs Alicia Smith
(Address) 436 N. Register

15 Filed 19 C. BRANSON JONES, M. D. Registrar
AUG 25 1930 m.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24/ 19 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24 19 30 to Aug 24 19 30
that I last saw h alive on Aug 23 19 30
and that death occurred, on the date stated above, at 3:58 m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
4
(duration) yrs. mos. ds.
CONTRIBUTORY not known
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? not known
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? none
(Signed) Richard C Eveleigh M. D.
(Address) 1614 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery
Date of Burial Aug 25 19 30

20 UNDERTAKER H E Whelan
ADDRESS 1515 W Lexington St

Of DEATH is plain terms, so that it may be of property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 60013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 60013

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. ..... ST. 27-56 WARD)

2-FULL NAME Hilda Massey

(a) RESIDENCE NO. Melvale Indus. School ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Colored

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... G. Hyman Boyd JONES, M. D.
Registrar

AUG 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to August 20, 1930,

that I last saw her alive on August 20, 1930,

and that death occurred, on the date stated above, at 11.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jenner, M. D.

8-21 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS AUG 25 19

Spec.—1-30—M. & T.—250 Bks

E 60014

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60014

CERTIFICATE OF DEATH.

31

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T. B.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Clarence Gaines

(a) RESIDENCE NO. 2218 Morris st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Gaines

6 DATE OF BIRTH (month, day, and year) March 22, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 023

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jesse Gaines

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Lizzie Rambley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Kentucky

14 Informant Hospital Records

(Address)

15 Filed AUG 25 1930 C. H. Peek JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1930, to Aug. 22, 1930, that I last saw him alive on Aug. 22, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jenner, M. D.

8-22, 1930 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL AUG 25, 1930

20 UNDERTAKER Commissioner Health

ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 60015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 60015

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Baltimore City Hosp. ST., 76-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Ryan

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-15-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone mason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fairfield (State or country) Connecticut

PARENTS

10 NAME OF FATHER Thos. Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of Baltimore City Hosp. (Address)

15 Filed ..... 19 ..... C. Klein JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-21-30

17 I HEREBY CERTIFY, That I attended deceased from 11-15- , 19 15 , to 8-21- , 19 30 ,

that I last saw h im alive on 8-21- , 19 30 ,

and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Thrombosis, rt. middle cerebral artery

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocard. dis. CHRONIC (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1. Hospital 2. Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget. M. D.

8-25, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

AUG 25 1930

Spec.—1-10-21—M&T—1500 Blks.

E 60016

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60016

CERTIFICATE OF DEATH.

X 43

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Effie Petrei (Pitner)

(a) RESIDENCE NO. 1111 N. St N.W. Wash D.C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl Pitner

6 DATE OF BIRTH (month, day, and year): June 13/90

7 AGE: Years 40; Months 2; Days 10; If LESS than 1 day, hrs. or min. 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: Ill

9 BIRTHPLACE (city or town) (State or country): Ill

PARENTS

10 NAME OF FATHER: Marion L. Posson

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Phoebe Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Carl Petrei

(Address) Arcadia Hotel Washington DC

C. HAMPSON JONES, M. D.

Registrar

19 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-24 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-22, 1930, to 8-24, 1930, that I last saw her alive on 8-24, 1930, and that death occurred, on the date stated above, at 9.20 a m. E Stand Time

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue & metastases to gland of neck

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): P O Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Removal of Gland Date of 8-23-30

Was there an autopsy? No

What test confirmed diagnosis? Frozen Sec. Path.

(Signed) Hyalmar S Anderson M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jacksonville Ill.

DATE OF BURIAL: 8/25 1930

UNDERTAKER: Philip Herwig

ADDRESS 206 Adams

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 60017 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60017

38

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 3-4 WARD)

2-FULL NAME Joseph Avery

(a) RESIDENCE NO. 206 S. Dallas St. ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 687

(c) Name of employer

9 BIRTHPLACE (city or town) ? Unknown
(State or country) ? "

PARENTS

10 NAME OF FATHER ? "

11 BIRTHPLACE OF FATHER (city or town) " ?
(State or country) "

12 MAIDEN NAME OF MOTHER ? "

13 BIRTHPLACE OF MOTHER (city or town) " ?
(State or country)

14 Informant Records of Baltimore City Hospitals
(Address)

15 FILED 8 25 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-22-30

17 I HEREBY CERTIFY, That I attended deceased from 8-20-30, 19..., to 8-22-, 19 30, that I last saw h im alive on 8-22-, 19 30, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Thrombosis, rt. anterior cerebral artery.

(duration) ...yrs. mos 4 ds. OBW

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ...yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? In Hosp. City Jail.

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padgett. M. D.

8.25. 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	Aug 25 1930
UNDERTAKER	ADDRESS
Harry H. Witzke	4401 Edmondson

Registrar

Spec.—1-30—M. & T.—250 Bks.

Dr Magness
1206 E Preston

E 60018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 60018

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 East Preston ST., 9-18 WARD)

2-FULL NAME Thomas H. S. Harding Sr

(a) RESIDENCE NO. 1210 East Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth J. Harding

6 DATE OF BIRTH (month, day, and year): Feb 24, 1851

7 AGE: Years 79 | Months 6 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Ret

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Francis A Harding

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ann Swann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Eliza J. Harding (Address) 1210 E Preston

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/25/30

17 I HEREBY CERTIFY, That I attended deceased from 8/1/30, 19..... to 8/25/30 19.....

that I last saw him alive on 8/25/30, 19.....

and that death occurred, on the date stated above, at 9.40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Lee Magness M. D.

8-25 1930 (Address) 1206 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Aug 28 1930

20 UNDERTAKER: William Cook

ADDRESS: 1217 E Lanvale

Spec.—1-30—M. & T.—250 Bks

E 60019 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60019

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Munder

(a) RESIDENCE NO. 128 N. Lakewood Ave. or 826 Newington Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of or) WIFE of Julius Munder

6 DATE OF BIRTH (month, day, and year) 7-1-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James Neely

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Penna.

12 MAIDEN NAME OF MOTHER Mollie E. Matson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Records of Baltimore City Hosp. (Address)

Filed 8 25 1930, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24-30

17 I HEREBY CERTIFY, That I attended deceased from 1-26-29, 19..., to 8-24-, 1930, that I last saw her alive on 8-24-, 1930, and that death occurred, on the date stated above, at 2:25 P.m.

The CAUSE OF DEATH* was as follows:

Dementia, senile,
Pre-senile form
(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

8-25-1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetary — DATE OF BURIAL 8/26/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60020

CERTIFICATE OF DEATH.

129 E 60020

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1624 Fleet St. 9-4 Ward)

2-FULL NAME ELIZABETH ROCKEL

(a) RESIDENCE NO. 1624 Fleet St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Rockel

6 DATE OF BIRTH (month, day, and year) May 14, 1855

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Weislein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Mrs. Mary Levie (Daughter)

(Address) 1713 Couch St.

Filed ..... 19..... C. HAMPSON JONES, M. D., Registrar.

By .....

2 5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. 1 mos. ds.

(Signed) James M Hanlon M. D.

(Coroner)

8 26 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 1624 Fleet yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1624 Fleet

Former or usual residence same

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

Date of Burial Aug. 28 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore & Fremont

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60021

E 60021

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 558 W. Pratt ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Hall

(a) RESIDENCE NO. 558 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widnwed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Hall

6 DATE OF BIRTH (month, day, and year): May 10-1877

7 AGE: Years 53 | Months 3 | Days 12 1/3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Stevedore

(c) Name of employer: Calvert Co.

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co Md

14 Informant: Chas Hall

(Address) 1928 N. Stricker

Date 8-25-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1930 to Aug 23, 1930

that I last saw him alive on Aug 23, 1930

and that death occurred, on the date stated above, at 1P.M.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operatinn precede death? No Date of

Was there an autopsy? No

What test cnnfirmed diagnosis?

(Signed) Jas E Dell, M. D.

, 19 (Address) 1913 N. Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery

DATE OF BURIAL: Aug 26 1930

20 UNDERTAKER: Thomas E. Nelson

ADDRESS: 1005 Pittsman St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60022

CERTIFICATE OF DEATH

129

E 60022

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balto City Hospital St., 15-22 Ward)

2-FULL NAME Henry Woodland

(a) RESIDENCE NO. 1357 Wheat Coat St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Woodland

6 DATE OF BIRTH (month, day, and year) March 5 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) St Mary's Co.

PARENTS

10 NAME OF FATHER John Woodland

11 BIRTHPLACE OF FATHER (city or town)
(State or country) St Mary's Co.

12 MAIDEN NAME OF MOTHER St Mary's Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Annie Woodland
(Address) 1357 Wheat Coat St

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

AUG 25 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) about yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated heart

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Ferguson M. D.

8 25 1930 (Address) 702 Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL Aug 26 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 303 Biddle St

IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Mary S. Atwell ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60023

CERTIFICATE OF DEATH

44 E 60023

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3304 Hamilton Ave. ST., 27-43 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary S. Atwell.

(a) RESIDENCE NO. 3304 Hamilton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 4 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George A. Atwell.

6 DATE OF BIRTH (month, day, and year) April 6, 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	83.	4.	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas W. Spencer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Frankintown, Md.

12 MAIDEN NAME OF MOTHER Ann M. Barton.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont Know.

14 Informant George T. Atwell. (Son).
(Address) 3304 Hamilton Ave.

15 Filed AUG 25 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1930, to Aug 23, 1930, that I last saw her alive on Aug 23, 1930 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Diabetes Mellitus

(duration) yrs. 1 mos. 25 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. D. Stevens, M. D.

8/24, 1930 (Address) 2578 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem DATE OF BURIAL Aug 26, 1930

20 UNDERTAKER E. Howard Evans ADDRESS 8 W. Mt Vernon Pl

Spec.—1-12-29—M&T—500 Blks.

E E 60024 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 146 E 60024

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH West Baltimore Gen. Hosp. ST. 16-27 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. C

2-FULL NAME Mrs Lillie J. Wagenfar

(a) RESIDENCE NO. 604 N Bruce St. ST., WARD E

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel A. Wagenfar

6 DATE OF BIRTH (month, day, and year) Oct 10, 1828

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
2	10	12	

* OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37 ✱

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot County Md

PARENTS

10 NAME OF FATHER Jorge Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Clara E Talbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co Md

14 Informant Samuel A Wagenfar

(Address) 604 N Bruce St

Filed AUG 26 1930 C. BAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Aug 23, 1930, that I last saw h e alive on Aug 23, 1930 and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Incomplete Infected Abortion

Left Suphrenic Abscess

Pelvic Abscess.

(duration) yrs. 25 mos ds.

CONTRIBUTORY (Secondary) Heart failure --

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of H/O Operation

Was there an autopsy?

What test confirmed diagnosis? B-Col. injection Clinical

(Signed) H. Cahnman, M. D.

19 (Address) West Balto Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Aug 26 1930

ADDRESS 1832 Eutaw Pl

20 UNDERTAKER F. Weinmeister

FROM a very important collection of Baltimore City Death Certificates

Spec.—1-30—M. & T.—250 Bks.

E 60025 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60025

CERTIFICATE OF DEATH.

REGISTERED NO. 118-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Caplan

(a) RESIDENCE No. 1633 N. Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Bessie

6 DATE OF BIRTH (month, day, and year) Jan 15/1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor & Cl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Israel Caplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Ebser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Julius Caplan (Address) 1627 N. Appleton St

15 Filed Aug 26 1930 C. MADDOX JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1930, to Aug 25, 1930, that I last saw him alive on Aug 25, 1930, and that death occurred, on the date stated above, at 12:30 P.m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia (Operation)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Paralytic Ileus Postoperative

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 21, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Irwin J. Cohen M. D.

8/26, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Sholom Cem

DATE OF BURIAL Aug 26 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Baltimore St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-002 ✓

E 60026

E 60026

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 Maryland Ave ST. 12-51 WARD)

2-FULL NAME Effie May Morrison.

(a) RESIDENCE NO. 2113 Maryland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harvey C. Morrison

6 DATE OF BIRTH (month, day, and year) March 29 1878

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.
(State or country)

PARENTS

10 NAME OF FATHER Hiram W. Frue

11 BIRTHPLACE OF FATHER (city or town) Ill.
(State or country)

12 MAIDEN NAME OF MOTHER Lina Heide

13 BIRTHPLACE OF MOTHER (city or town) Ger.
(State or country)

14 Informant Harvey C. Morrison
(Address) 2113 Maryland Ave

Filed 8-6-1930 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24/30

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to August 24th, 1930, that I last saw him alive on Aug 24th, 1930, and that death occurred, on the date stated above, at 11.35 P. m.

The CAUSE OF DEATH* was as follows:

1. Hodgkins Disease

(duration) yrs. 7 mos da.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Foote, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL June 22 19 30

ADDRESS 3615 Clifton

20 UNDERTAKER Thurnwald Lore

Spec.—1-30—M. & T.—250 Bks

E 60027 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60027

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 17-24 ST. WARD)

2-FULL NAME Vance McKeever

(a) RESIDENCE NO. 1106 Argyle ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Elizabethtown (State or country) North Carolina

PARENTS

10 NAME OF FATHER David McKeever

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address)

15 Filed 8-26 1930. 19 H. Hamilton Johns M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 22, 19 30. to Aug. 22, 19 30.

that I last saw him alive on Aug. 22, 19 30.

and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) David Jeuner, M. D.

8-22, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Aug 26 1930

20 UNDERTAKER E. L. Brown & Son

ADDRESS 116 W. Monty St

Spec—12-23-21—E.B.F.S.—400 Blks.

E 60028

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60028

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 945 Madison ave St. ..... Ward) 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Thurman

(a) Residence No. 945 Madison ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Clifton Thurman

6-DATE OF BIRTH (month, day and year)

7-AGE: 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Service

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Va.

PARENTS.

10-NAME OF FATHER, ...

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14-Informant: Clifton Thurman

(Address): 945 Madison Ave.

15-Filed 2 6 1930, 192 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 8/24/30

17- I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1930 to Aug. 24, 1930

that I last saw her alive on Aug. 24, 1930

and that death occurred, on the date stated above, at 8:35 A m.

The CAUSE OF DEATH* was as follows:

Paralysis 10 hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage about 10 hours

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H Hemphrine M. D.

8/25, 1930 (Address) 1012 N. Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Aug 26 1930

20-UNDERTAKER: Samuel Steusloff

ADDRESS 508 N Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60029

CERTIFICATE OF DEATH

E 60029

REGISTERED NO. 161-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 Eldorth St, ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joby Sharpe

(a) RESIDENCE NO. 1733 Eldorth St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	aa	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 24, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer no

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Sharpe

11 BIRTHPLACE OF FATHER (city or town) (State or country) SC

12 MAIDEN NAME OF MOTHER Odella Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Odella Sharpe (Mother)

(Address) 1733 Eldorth St

Filed AUG 26 1930 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1930, to Aug 24, 1930, that I last saw h[illegible] alive on Aug 24, 1930 and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth and Physical condition of mother

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Physical condition of Mother

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) H. D. Hall, M. D.

19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary cemetery

DATE OF BURIAL Aug 26 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Ashland Ave

Cor—12-9-25—A Co—200 Bks.

E 60030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 60030

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospt. St. 18-26 Ward)

2-FULL NAME Hiland Robinson

(a) RESIDENCE NO. 520 N. Schroeder St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3, 1896

7 AGE: Years 34 Months 7 Days 18 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Robinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Robinson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Catherine Nelles
(Address) 520 N. Schroeder St.

15 Filed Aug 26 1930 H. LEMMON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis about one yrs. (duration) mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart (duration) yrs. mos. 3 ds.

(Signed) James M Fenton M. D. (Coroner)

Aug 25 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) In the State

At place of death Balto City Dep't yrs.. mos.. ds. yrs.. mos. 20 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Date of Burial Aug 26 1930

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1725 Eastlander

very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60031

CERTIFICATE OF DEATH

8-45

90 V

E 60031

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Swett

(a) RESIDENCE NO. 1663 Cliftview Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assists in HW

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Otto Frank

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

14 Informant Records of Balto. City Hospitals
(Address)

15 Filed 8-26, 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24-30

17 I HEREBY CERTIFY, That I attended deceased from 7-21, 1930, to 8-24-, 1930, that I last saw h er alive on 8-24-, 1930, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) UNKNOWN yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? City Hosp. 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Pudge M. D.

8-25, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. New York City

20 UNDERTAKER William Cook

DATE OF BURIAL 8/27/1930

ADDRESS 1275 St Paul

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60032

CERTIFICATE OF DEATH

E 60032

187-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Brought Dead at

City of Baltimore: (No. Balt City Hospitals St., 27-43 (Ward)

2-FULL NAME Frederick Messner

(a) RESIDENCE NO. 2828 Roslawn ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Messner

6 DATE OF BIRTH (month, day, and year) June 8th 1868

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
62	2	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Schmeyer
(c) Name of employer Packing Co

9 BIRTHPLACE (city or town)
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Michael Messner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Walters

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Emma Messner
(Address) 2828 Roslawn ave

15 Filed 19 Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) investigation find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured L Side, chest
Ribs puncturing Lungs &
probably Heart, Accidental
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fall down Elevator Shaft
(duration) Sudden yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Kemler, M. D.

8 26 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	8/27/1930
20 UNDERTAKER Wm Cook 1217 E	ADDRESS Paul St

important. See instructions on back of certificate.

1-30—M & T.—100 B—50L

60033

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60033

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto Hosp ST. 24-33 WARD

2-FULL NAME Jno Edw Krogel

(a) RESIDENCE NO 4th Ave South Glenburnie ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alma E. Krogel

6 DATE OF BIRTH (month, day, and year) May-20-1904

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
	26	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shovel Board
(b) General nature of industry, business, or establishment in which employed (or employer) Installation
(c) Name of employer Western Elec

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jno Krogel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Phil Mrs A Workendyke (Address) Glenburnie Md

15 Filed ..... No. ..... JONES, M. D. Registrar

8 26 1930 C. HARRIS

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

18 CAUSE OF DEATH, was as follows:

Automobile in which he was a passenger caught afire when gas tank exploded causing

(a) ..... (Disease) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) 2nd & 3rd degree burns of upper extremities (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Glenburnie

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. Frame, M. D. Coroner

8 26 1930 (Address) 29 39 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls - Violetville — DATE OF BURIAL 8/27/1930

20 UNDERTAKER Jno. Waltemeyer & Son — ADDRESS 2503 Ed. Ave

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60034

CERTIFICATE OF DEATH

E 60034

REGISTERED NO. 24-33 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto Hosp ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Edw Krogen

(a) RESIDENCE NO 4th Ave South ST., Glenburnie WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 3 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Glenburnie

PARENTS

10 NAME OF FATHER Leo Edw Krogen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Rebecca E Rockenfuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Alma E. Krogen

(Address) Glenburnie, Md

15 Filed 2-6-1930 192 HAMPDEN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto in which he was a passenger
daughter afire when Gas tank
exploded

(a) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 2 degrees burns

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Glenburnie

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Frame, M. D. Coroner

(Address) 3939 W. Belvy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls - Ridgeville — DATE OF BURIAL 8/27/30

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Ed.

Spec.—1-30—M. & T.—250 Blks.

E 60035

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60035

161-001

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST. 15-62 WARD)

2-FULL NAME Baby Girl Blamberg.

(a) RESIDENCE NO. 3408 Wabash ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug. 23 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ✓ hrs. or 20 min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Lee Blamberg

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lewretta Plaxcomb

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Lewretta Blamberg
(Address) 3408 Wabash ave

Filed AUG 26 1930 HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1930 to ....., 19.....,
that I last saw her alive on Aug 23, 1930,
and that death occurred, on the date stated above, at 1 40 a m. (D.L.S.T.)

The CAUSE OF DEATH* was as follows:

Prematurity and anencephalus.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ✓ (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Rudolph J Schaefer, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Returned to Hospital.

DATE OF BURIAL ..... 19.....

20 UNDERTAKER

ADDRESS

Spec.—1-30—M. & T.—250 Bks

60036

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60036

CERTIFICATE OF DEATH.

51

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Lubinski

(a) RESIDENCE NO. 1005 S. Kenwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred lif yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married -Sep.

5a If married, widowed, or divorced HUSBAND of or) WIFE of ? John Lubinski

6 DATE OF BIRTH (month, day, and year) 10-1-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Make

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of Baltimore City Hosp. (Address)

15 Filed 8 26 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-21-30

17 I HEREBY CERTIFY, That I attended deceased from 7-30- , 19 30 , to 8-21- , 19 30 ,

that I last saw her alive on 8-21- , 19 30 ,

and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute, rheumatic

(duration) 5 yrs. mos da.

CONTRIBUTORY (Secondary) Auricular fibrillation (duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget M. D.

8-25-1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem DATE OF BURIAL Aug 27 1930

UNDERTAKER Stephen J. Fialkowski INC ADDRESS 1005 S. Kenwood Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60037

91-602

E 60037

CERTIFICATE OF DEATH

REGISTERED NO. 23-34

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Patapsco ST., 23 WARD)

2—FULL NAME Anna M. Lauterbach

(a) RESIDENCE NO. 1602 Patapsco ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. N. Lauterbach

6 DATE OF BIRTH (month, day, and year) Mch. 19-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER J. Kreibs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John. Lauterbach

(Address) 1602 Patapsco

15 Filed AUG 26 1930, 19 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24-30

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to Aug 24, 1930

that I last saw HER alive on Aug 24, 1930

and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) H. & K. Campbell, M. D.

8/25. 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 8/27 1930

20 UNDERTAKER J. Few McCully

ADDRESS 130 E Fort.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60038

101-001 E 60038

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Bonaparte ave ST., 9-46 WARD)

2-FULL NAME Philip Frank Wielert

(a) RESIDENCE NO. 1008 Bonaparte ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Wielert

6 DATE OF BIRTH (month, day, and year) Nov. 1

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66 Yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Wielet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Beckmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Wielert

(Address) 1008 Bonaparte Ave

15 Filed 8/26 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH 24 1930

16 DATE OF DEATH (month, day, and year) Aug [redacted] 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19 - 1930, to Aug. 24 - 1930, that I last saw h[redacted] alive on Aug. 24 - 1930 and that death occurred, on the date stated above, at 10-22 P. m.

The CAUSE OF DEATH* was as follows:

Double Pneumonia - Lobar

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

8/25 1930 (Address) 1223 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Aug 28 1930

20 UNDERTAKER Henry Haecker Sons Inc — ADDRESS 1301 E. Eager St

Spec.—1-30—M. & T.—250 Bks

60039 HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 60039

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 912 Stirling St. 10-14 (Ward)

2-FULL NAME George Andrew Petri

(a) RESIDENCE NO. 912 Stirling St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? Yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Dorothy M. Petri Not Known

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57 Yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamfitter 60

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Petri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sophia Kleickwelt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Dorothy Petri (Address) 912 Stirling St

15 Filed AUG 26 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to August 25, 1930, that I last saw him alive on August 24, 1930, and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure - Toxemia and Exhaustion

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gastric analysis

(Signed) William F. Schwartz, M. D.

8/25, 1930 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Aug 28 1930

UNDERTAKER Henry Hoeck & Sons Inc. — ADDRESS 1301 E. Eager St

Cer.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60040 ✓

E 60040

CERTIFICATE OF DEATH

1415 166

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., Ward)

2-FULL NAME Nancy E. Phipps.

(a) RESIDENCE NO. 911 N. Calvert St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married.

5a If married, widowed or divorced
(or) WIFE of Frank Phipps.

6 DATE OF BIRTH (month, day, and year) May 8, 1909

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	21	8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Frostburg, Md.
(State or country)

PARENTS

10 NAME OF FATHER David Phipps.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wales.

12 MAIDEN NAME OF MOTHER Annie Pierce.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Annie phipps. (mother.)
(Address) 26 Taylor St. Frostburg Md.

Filed AUG 26 1930 19 [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uraemia due to Bichloride of Mercury poisoning.
Suicide-

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death? C. C. Co. Md. August 20, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) M. M. Fernhall, M. D.

8/26, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frostburg Md.	Aug 28-1930
20 UNDERTAKER A. A. Hark	ADDRESS 1000 N. Pace St.

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60041

160 E 60041

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 S. Collington Ave. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Summers Jr.

(a) RESIDENCE NO. 237 S. Collington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): January 23 1930

7 AGE — Years: 7. Months: 1 Days: 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph Summers Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Alexander Sovick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hospot Pa

14 Informant: Joseph Summers

(Address) 237 S. Collington Ave

15 2 8 1930 (Registered) CHARLES JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25/30

17 I HEREBY CERTIFY, That I attended deceased from July — , 1930, to Aug 25 , 1930,

that I last saw h— alive on Aug 24 , 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mal-assimilation

3-4 Months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): general debility

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. C. O. Brauer, M. D.

19 (Address) 125 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem

DATE OF BURIAL: Aug 25 1930.

20 UNDERTAKER: Kendall & Propst

ADDRESS: Fulton Ave

Cor.—10-10-29—A Co.—100 Bks.

E 60042

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60042 Duplicate

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 867 W. Franklin St. 18 Ward) 31

2-FULL NAME Hattie Carter

(a) RESIDENCE NO. 867 W. Franklin St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Mrs Carter
(Address) 867 W Franklin

Filed 8 26 1930 10. MARRIAGE BOOKS, 19.. Registrar. Pk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemoptysis - probably due to Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Tilley, M. D.

8/25. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

20 UNDERTAKER Samuel Fastow

DATE OF BURIAL 8/26 1930

ADDRESS Pace

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

60043

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60043

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 S. Charles St. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Bettelman

(a) RESIDENCE NO. 1034 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rose Bettelman

6 DATE OF BIRTH (month, day, and year) April 5-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession of particular kind of work Rep. C45

(b) General nature of industry, business, or establishment in which employed (or employer) Specialty Shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Lewis (Address) 1439 Eutaw St.

15 Filed AUG 26 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25th-30

17 I HEREBY CERTIFY, That I attended deceased from June 13, 19 28, to Aug 25th, 19 30

that I last saw h. alive on Aug. 23rd, 19 1930

and that death occurred, on the date stated above, at 11 55 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical reason

(Signed) Eugene J Leopold M. D.

, 19 (Address) 200 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery

DATE OF BURIAL 8-26- 19 30

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eutaw St.

Spec.—1-30—M. & T.—250 Bks

E 60044 HEALTH DEPARTMENT—CITY OF BALTIMORE 69 E 60044

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Byrnes.

(a) RESIDENCE NO. Mercy Hospital ST., 2723 Hunsdale St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 COLOR OR RACE: White. 5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23, 1930

7 AGE: Years | Months | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. (M)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mercy Hospital Balto Md.

PARENTS

10 NAME OF FATHER Austin Byrnes.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER Blanche Duke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant (Address): Hospital Records

15 Filed AUG 26 1930 R.K. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25/30.

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1930, to Aug 25, 1930, that I last saw h living on Aug 25, 1930, and that death occurred, on the date stated above, at 2 35 8 m.

The CAUSE OF DEATH* was as follows:

Cyanosis Hemorrhagica.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopical & gross pathology

(Signed) L. Barnes Hamilton, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Aug 26 1930

ADDRESS: 501 E 22nd

20 UNDERTAKER: Mary M. Wiedefeld

Spec.—2-29-28—L. F. S.—500 Bks.

E 60045

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

CERTIFICATE OF DEATH

E 60045

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 25-75 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mabel Hoffman

(a) RESIDENCE NO. 3533 - 34 St. Boro, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of M. O. A. Hoffman

DATE OF BIRTH (month, day, and year) Dec. 22, 1903

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	8	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Roman Fiolek

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.

(State or country)

12 MAIDEN NAME OF MOTHER Annie Lowry

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.

(State or country)

14 Informant Mrs. M. A. Hoffman (Address) Md. General Hospital

15 Filed AUG 26 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/19/30, 19 30, to Aug 27, 19 30, that I last saw h.. alive on Aug 27, 19 30 and that death occurred, on the date stated above, at 3:55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of small intestine - Peritonitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Carcinoma of intestine

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 3533 - 34 St. Boro, Md.

Did an operation precede death? Yes Date of 5/19/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Robert T. Monroth, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Aug 26 1930

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60046 — 129 — E 60046

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3421 Wabash ave. (St.) 15-62 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Flaherty

(a) RESIDENCE NO. 3421 Wabash Ave ST., 15th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-17-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (Home)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Flaherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Constantine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. S. B. Goodhans
(Address) 3421 Wabash Ave

15 Filed 2-6 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1930, to Aug 24, 1930, that I last saw her alive on Aug 24, 1930, and that death occurred, on the date stated above, at 9:10 P m.

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic Interstitial)

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart - Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? The usual

(Signed) Wm A. Duvall, M. D.

, 19 (Address) 3523 Liberty Hts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interbath-bem

DATE OF BURIAL 8/27 1930

20 UNDERTAKER J. A. Moran

ADDRESS 3000 E Baltimore

Spec.—1-10-21—M&T—1500 Blks.

E 60047 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60047

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Pulkney & Gatons Avenue ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gibson Smith.

(a) RESIDENCE NO. 323 E 21 St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Catherine Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
22	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Gibson C Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick

12 MAIDEN NAME OF MOTHER Maud C Pyke

13 BIRTHPLACE OF MOTHER (city or town) Frederick. (State or country)

14 Informant Mrs Catherine Smith (Address) 323 E. 21st City

15 Filed 7-31-1930 19 Day E. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-19, 1930, to 8-25, 1930.

that I last saw h~~im~~ alive on 8-25, 1930,

and that death occurred, on the date stated above, at 3:10 m. S.T

The CAUSE OF DEATH* was as follows:

Sarcoma of Ileum

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Recurrence of Metastases

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Frozen Section

(Signed) Hjalmar S. Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Frederick Md

DATE OF BURIAL Aug 28 1930

20 UNDERTAKER Mary Mc Wimsfield

ADDRESS 501 E 22nd

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60048

CERTIFICATE OF DEATH.

90 E 60048

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry H. Forbes

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1st 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	89	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Augustus Forbes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Angelina Bannington

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St.

Filed AUG 26 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Aug 26, 1930,

that I last saw him alive on Aug 19, 1930,

and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Internal capsule

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis & Myocarditis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Wm. H. Grigsby, M. D.

8/26 1930 (Address) 2225 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cremation

DATE OF BURIAL. Aug 27 1930

ADDRESS

20 UNDERTAKER Robt. J. Weisfeld 914 Greenmount Ave

G 26 1930 SAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 60049

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60049

CERTIFICATE OF DEATH.

161-01

REGISTERED NO. 13-52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3737 Roland Av ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hanson

(a) RESIDENCE NO. 3737 Roland Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 26 30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John F Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Irene Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant Irene Hanson (Address) 3737 Roland Av

15 Filed AUG 26 1930 C. HAMPSON JONES, M. D. Registrar

Dep. Wm E. WOODALL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1930, to Aug 26, 1930, that I last saw h alive on Aug 26, 1930, and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Ryan M. D.

Aug 26 1930 (Address) 801 Kenwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL AUG 26 1930

20 UNDERTAKER Commissioner Health. ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 60050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60050

REGISTERED NO. 9-462

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4101 Hillen Road ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgia C. Boyd

(a) RESIDENCE NO. 4101 Hillen Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

a If married, widowed, or divorced: HUSBAND of (or) WIFE of William B. Boyd

6 DATE OF BIRTH (month, day, and year) April 13, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER James A. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Savage Maryland

12 MAIDEN NAME OF MOTHER Evelyn Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Virginia

14 Informant: Mr. William B. Boyd

(Address): 4101 Hillen Road

15 Filed: 6 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 7 . 1930 . to Aug 25 . 1930 .

that I last saw her alive on Aug 22 . 1930

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8/25 1930 (Address) 2923 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Aug. 27 1930

20 UNDERTAKER: D. H. D. Cook

ADDRESS: 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

E 60051 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60051

CERTIFICATE OF DEATH.

REGISTERED NO. 27-56 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3207 Virginia Ave ST. 27 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca T. Hutchins

(a) RESIDENCE NO. 3207 Virginia Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ or WIFE of: William T.

6 DATE OF BIRTH (month, day, and year): Sept 16th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	79	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Horace Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Straughn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Miss Daisy Hutchins

(Address) 3207 Virginia Ave

15 Filed 2 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25th 1930

17 I HEREBY CERTIFY, That I attended deceased from May - 1, 1930, to Aug - 25, 1930,

that I last saw him alive on Aug 24, 1930,

and that death occurred, on the date stated above, at 12 noon,

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis,

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Martin W. Shook, M. D.

8, 26, 30 (Address) 2067 Fulton ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetary — DATE OF BURIAL: 8/28/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul st

1-30—M. & T.—100 B—50L

E 60052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

198 E 60052

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital 3-5 WARD)

2-FULL NAME Andrew Clemens or Anthony Klimcak

(a) RESIDENCE NO 46 Albemarle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? about 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married or widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 55				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Canning Industries
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER George Klimcak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland (Austria)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Eastern Police

(Address)

Filed 8 26 1930, 19 C. HAMPSON JONES, M. D. Registrar

By RRK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to stab wound of neck

Homicide (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. H. Fallen, M. D.
Coroner

8/26/30 (Address) 508 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 8/27/30 19

20 UNDERTAKER George J. Pfeltz Sons — ADDRESS 1735 Hanford

1-30—M & T—100 B—501.

E 60053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60053

REGISTERED NO. 146

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. ST. 4428 WARD

2-FULL NAME Mrs. Marie Manthe

(a) RESIDENCE NO. 1628 Hollins ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Manthe

6 DATE OF BIRTH (month, day, and year) June 2 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
26	—	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Stiebeling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Manthe

(Address) 1628 Hollins

15 Filed AUG 26 1930 16 C. HAMPSON JONES, M. D. Registrar

Per R.C.H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows: Septic poisoning resulting from Abortion, Self induced

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas. H. Brooke M. D. Coroner

Aug 27, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Aug 27 1930

20 UNDERTAKER Geo L Schwab

ADDRESS 2101 Frederick Ave

Cor.—10-10-29—A Co.—100 Bks.

E 60054

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 60054

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 24-34 Ward)

2-FULL NAME Rose L. Helms.

(a) RESIDENCE NO. 1706 Belt St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) April 15, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	3	4	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Leo Helms.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Gladys Thompson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Gladys Helms, (mother)
(Address) 1706 Belt St.

15 Filed ..... 19..... C. HAMPSON JONES, M. D.
Registrar

2 6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25, 1930 192

17 I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentot fell from o ster.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted 1706 Belt St. August 24, 1930
If not at place of death?

Did an operation precede death? Yes. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) M. A. Leuhardt, M. D.

8/26. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethesda	8/27 1930
20 UNDERTAKER	ADDRESS
J. F. Tabler & Son	131 E. Lex

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 60055 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60055

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 512 S. Durham ST. 2-4 WARD)

2-FULL NAME Anna Skonieczna

(a) RESIDENCE NO. 512 S. Durham St. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 10

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Larence Skonieczna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Kuegurde Wilczak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Katarzyna Dolisz 512 S Durham ST.

Filed 8 6 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-25-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Aug 25, 1930, that I last saw her alive on Aug 24, 1930, and that death occurred, on the date stated above, at 5 P.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) Gradual yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilden M. D.

8/26 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Aug 19 30

DATE OF BURIAL

ADDRESS

20 UNDERTAKER John J. Welch & Son Chester

Spec.—1-30—M. & T.—250 Bks.

239203
E 60056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113E 60056

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard White

(a) RESIDENCE NO. 1724 Jackson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June-3-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work chld

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Bernard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Genevieve Wojciechowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed 2 6 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25-30

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to Aug 25, 1930, that I last saw him alive on Aug 25, 1930, and that death occurred, on the date stated above, at 11 40 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal disturbance

Entero-colitis

(duration) yrs. 1 1/2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mastoidectomy

Did an operation precede death? yes Date of 8-12-30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. L. Goodwin, M. D.

9/26, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL Aug 28 1930

20 UNDERTAKER John M Weber

ADDRESS 401 N Chester St

Spec.—1-30—M. & T.—250 Bks.

Mina Baer ✓

E 60057

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60057

CERTIFICATE OF DEATH.

46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 120 W. Clement St. 24-33 (WARD)

2-FULL NAME Mina Baer.

(a) RESIDENCE NO. 120 W. Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 10 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of George Baer.

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53,	10,	1,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Christopher Kramer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Oren.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Emma Greb. (Address) 120 W. Clement St.

15 Filed 2 6 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1929, to Aug. 25, 1930, that I last saw her alive on Aug 25, 1930, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus (duration) Indefinite hrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. L. Campbell M.D.

8/26 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Aug 28, 1930

20 UNDERTAKER A. Howard Evans ADDRESS 32 E Fayette

G. HAMPSON JONES, M. D. Registrar

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60058

CERTIFICATE OF DEATH.

129

E 60058

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1103 Harlem av ST. (WARD) 16-26

2-FULL NAME Rebecca Bennett

(a) RESIDENCE NO. 1103 Harlem av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): May 10. 1868

7 AGE: Years 62; Months 3; Days 15; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Katy Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Sophia Price

(Address) 1103 Harlem ave

Filed 2 7 1930, 19.. C. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25 1930

17 I HEREBY CERTIFY, That I attended deceased from June 24. 1930. to Aug 25. 1930.

that I last saw h[illegible] alive on Aug 25. 1930.

and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) nephritis (duration) one yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 16 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: Aug 28 1930

20 UNDERTAKER: Joseph A Lively — ADDRESS: 4022 Mount st

Spec.—1-30—M. & T.—250 Bks

E 60059

HEALTH DEPARTMENT—CITY OF BALTIMORE

1221 E 60059

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 22-30 WARD)

2-FULL NAME Chas E. Beard

(a) RESIDENCE NO. 548 S. Paca St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Delia Beard

6 DATE OF BIRTH (month, day, and year) July 4, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) / / /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel Beard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Records of Balto. City Hosp. (Address)

15 Filed AUG 27 1930 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24-30

17 I HEREBY CERTIFY, That I attended deceased from 8-16-30, 19..., to 8-24-, 19 30,

that I last saw h in alive on 8-24-, 19 30,

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Hepatitis, acute, toxic

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Nephritis, acute

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

8-26, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Aug 29 1930

20 UNDERTAKER J. C. Tranel Son

ADDRESS 103 Hanover St.

Spec.—1-30—M. & T.—250 Bks

E 60060

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60060

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 629 ST. WARD)

2-FULL NAME Henrietta De Shields

(a) RESIDENCE NO. 420 Register St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married.

5a If married, widowed, or divorced ~~HUSBAND~~ of or) WIFE of Wesley de Shields.

6 DATE OF BIRTH (month, day, and year) July 7, 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Smyrna Delaware.

PARENTS

10 NAME OF FATHER Reese Jakes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) del.

12 MAIDEN NAME OF MOTHER Suby ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) del

14 Informant (Address) Records BALTIMORE CITY HOSPITALS

15 Filed 2 7 1930 19 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to Aug. 24, 1930, that I last saw her alive on Aug 24, 1930, and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) unknown. yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Hodgt. M. D.

8-25-1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Osborn cemetery

DATE OF BURIAL aug 27 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

Spec.—1-30—M. & T.—250 Bks.

E 60061 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 60061

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 850 N. Lombard St ST. 16-29 WARD)

2-FULL NAME William L. Jones,

(a) RESIDENCE NO. 850 N. Lombard St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Rosa B. Jones,

6 DATE OF BIRTH (month, day, and year) Oct 17. 1864.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman,

(b) General nature of industry, business, or establishment in which employed (or employer) Tube Works,

(c) Name of employer Betts. Tube Works,

9 BIRTHPLACE (city or town) (State or country) Wales.

PARENTS

10 NAME OF FATHER Wm J. Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales.

12 MAIDEN NAME OF MOTHER Eliz. Hughes,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales.

14 Informant Rosa B. Jones
(Address) 850 N. Lombard St

15 Received AUG 27 1930, 19.. C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930 to Aug 25, 1930, that I last saw him alive on Aug 25, 1930, and that death occurred, on the date stated above, at 3 35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endo-Carditis.
(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis
(duration) — yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam Etc.

(Signed) C. Harrison Jones, M. D.

8/26, 19.. (Address) 858 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 28 1930

20 UNDERTAKER Vernon Eschner — ADDRESS 1532 Hollins

Spec—12-23-2—E.B.K.S.—400 Bks.

E 60062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60062

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1312 Longwood St., 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Protsmarkle

(a) Residence No. 1312 Longwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Morgan Nefe

6-DATE OF BIRTH (month, day and year) 1871

7-AGE 58 yrs. 6 mos. 8 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS

10-NAME OF FATHER Edward Eimes

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa

12-MAIDEN NAME OF MOTHER Eby Eimes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa

14- (Informant) William E. Protsmarkle

(Address) 1312 Longwood St

15- (Filed) AUG 27 1930 (Registrar) C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 26-1930

17- I HEREBY CERTIFY, That I attended deceased from June 26 1930 to Aug 26 1930

that I last saw h alive on Aug 25 1930

and that death occurred, on the date stated above, at 3.50 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(Duration) yrs. mos. 10 ms.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. E. Allen M. D

8/26/30 (Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loft Lincoln DATE OF BURIAL. Aug 28 1930

20-UNDERTAKER. Sarah Snyder Hedgeville ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 60063

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 60063

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 S Broadway ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Fradkin

(a) RESIDENCE NO. 314 S Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Max Fradkin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) 1439 Eutaw St

15 Filed Aug 27 1930 Clerk Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 30

17 I HEREBY CERTIFY, That I attended deceased from Febr 20, 1930, to Aug 26, 1930

that I last saw h alive on Aug 26, 1930

and that death occurred, on the date stated above, at 9-45 P. m.

The CAUSE OF DEATH* was as follows: Interstitial Nephritis Cardiac dilatation

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Nathan Leffler M. D.

, 1930 (Address) 11 E Pleasant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Mt. Carmel

DATE OF BURIAL 8-27-1930

20 UNDERTAKER Jos Lewis, 1439 Eutaw St

ADDRESS

1-30—M. & T.—100 B—50L

E 60064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60064

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enroute Hopkins Hospital ST., 7-9 WARD)

2-FULL NAME Josephine Delma Holmes

(a) RESIDENCE NO Turner's Station ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? 1 day yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 1/1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	5	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lillie C. Joyner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lillie C. Holmes
(Address) Turner's Station

15 Filed 8-27-1930 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26/30.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidently drowned while sailing toy boat at Edgewater Beach, Turner Station.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Holmes, M. D. Coroner

8/27/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cem DATE OF BURIAL Aug 27 1930

20 UNDERTAKER Wm. M. Howe & Son ADDRESS 1100 Madison

Cor.—12-9-25—A Co.—200 Bks.

60065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90E 60065

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. in Way & Mercy (Hosp) St. 47-9 (Ward)

2-FULL NAME Mrs Emma Hess

(a) RESIDENCE NO. 141 E. North St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of Martin Hess

6 DATE OF BIRTH (month, day, and year): May 24. 1846

7 AGE: Years 84 Months 3 Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Miss L. Hess

(Address) 141 E. North ave

Filed Aug 27 1930 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Arterial Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed M. D.

Aug 26 1930 (Address) (Coroner) 1609 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Aug 29. 30

20 UNDERTAKER: Martin Fahey Sons — ADDRESS: 1827 W. North Ave.

Very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 60066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 118-802 E 60066

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 14-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Culver

(a) RESIDENCE No. Tessops Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Elsworth Culver

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Rodolphus Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) East.

14 Informant Hospital Records (Address) Baltimore, Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/30

17 I HEREBY CERTIFY, That I attended deceased from 8/26/30, 1930, to 8/27, 1930, that I last saw h[illegible] alive on 8/27, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 5 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Zapine lavage

(Signed) Wm. J. Sullivan M. D.

, 19 (Address) South Baltimore Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL To Laurel, Md

DATE OF BURIAL Aug 30 1930

20 UNDERTAKER Elwood N. Fisher

ADDRESS Laurel, Md

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60067

E 60067

CERTIFICATE OF DEATH

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital, 11-2 Ward)

2-FULL NAME Ella E. Lowman

(a) RESIDENCE NO. 1122 Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank Lowman

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Wade Caughman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Grace Holmes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant Jasper Holmes
(Address) 1709 W Lanvale

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Clinical

(Signed) James M Fenton, M. D.

8 27 1930 (Address) 7002 Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 8/30/30

20 UNDERTAKER Jno. Gs. H. Holland

ADDRESS 164 Druid Hill Ave

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60068

CERTIFICATE OF DEATH

E 60068

REGISTERED NO. 74001

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No.) 1514 Division St. (WARD) 11th

2-FULL NAME Courtney Carter

(a) RESIDENCE NO. 1417 Madison Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wm. T. Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lynchburg. (State or country) Va.

PARENTS

10 NAME OF FATHER Washington Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Wm. T. Carter (Address) 1417 Madison Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1930, to Aug 26, 1930, that I last saw h[illegible] alive on Aug. 26, 1930, and that death occurred, on the date stated above, at 3.35 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Hypertensive Cardiovascular factor (duration) yrs. mos. not known ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg, Va

DATE OF BURIAL 8/28/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1201 Druid Hill Ave

Spec.—1-30—M. & T.—250 Bks.

E 60069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 60069

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Callow Ave ST., 13-59 WARD)

2-FULL NAME Ethel Bachman

(a) RESIDENCE NO. 2117 Callow Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: Manuel Bachman

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 50; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Lewis (Address) 1439 Balto St

Filed 8-27 1930 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19 [illegible], to Aug 26, 19 30,

that I last saw h[illegible] alive on Aug. 26, 19 30,

and that death occurred, on the date stated above, at 12 M midnight.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Victor E. Levy, M. D.

Aug 19 30 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cemetery

DATE OF BURIAL: 8-27-19 30

20 UNDERTAKER: Jack Levine

ADDRESS: 1439 E Balto St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60070

CERTIFICATE OF DEATH

179E 60070

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St. 13-57 Ward)

2-FULL NAME Robert Joyce.

(a) RESIDENCE NO. 4086 Evans Chapel Rd. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 9 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widow,

5a If married, widowed, or divorced.
HUSBAND of ~~or WIFE of~~ Jinny E. Joyce.

6 DATE OF BIRTH (month, day, and year) November 20, 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	47	9	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer, 040
(b) General nature of industry, business, or establishment in which employed (or employer) U. Md Grain Elevator.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Thelma C. Joyce. (daughter)
(Address) 4086 Evans Chapel Rd.

15 Filed AUG 27 1930 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burns about the face and body due to an explosion in U. Md. G. E. Grain Elevator. Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? U. Md. Grain Elevator. August 20, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) M. Leonard, M. D.

8/27, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Aug 29 1930
20 UNDERTAKER Samuel Dolan	ADDRESS 26 E. Fayette St.

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 60071 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60071

CERTIFICATE OF DEATH. 108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Pulaski St 19-27 WARD)

2-FULL NAME Mary Grace Haugent

(a) RESIDENCE NO. 511 N Pulaski St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER James J. Neugent

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Susannah D. Dixon

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Susannah D. Neugent
(Address) 511 N. Pulaski St.

15 [illegible] 27 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from August 22nd, 1930, to August 27th, 1930, that I last saw her alive on August 27th, 1930, and that death occurred, on the date stated above, at 10-05 A m.

The CAUSE OF DEATH* was as follows:

Uremia Coma (over)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Ulcerative Stomatitis + Anaemia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. L. Kessler, M. D.

Aug 27, 1930 (Address) 1924 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug. 29 1930

20 UNDERTAKER Wm. C. Black

ADDRESS 922 N. Broadway

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60072

CERTIFICATE OF DEATH.

90 E 60072

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1929 Mc Culloh St. (WARD) 14-20

2-FULL NAME Wm. T. Robinson

(a) RESIDENCE NO. 1929 Mc Culloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Irma

6 DATE OF BIRTH (month, day, and year): July 14 - 1880

7 AGE: Years 50 55 / Months / Days 17

If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laster 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Moses Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Nellie Kaumbley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mary Robinson (Address) 1929 Mc Culloh St

15 Filed 2 7 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 26, 1930, that I last saw h[illegible] alive on July 26, 1930, and that death occurred, on the date stated above, at 1.05 PM

The CAUSE OF DEATH* was as follows:

Valvular heart lesion

Uremia (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Coleman M. D.

July 26, 1930 (Address) 2039 Mc Culloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 8/29/1930

ADDRESS

20 UNDERTAKER: Mrs. Geo. C. Holland 1631 Druid Hill

Spec.—1-30—M. & T.—250 Bks

E 60073

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60073

160

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3455 Tuke St. S. 13-57 WARD)

2-FULL NAME Juan Sater

(a) RESIDENCE NO. 3455 Tuke St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 4 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Charles Sater

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Emma Minton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Charles Sater (Address) 3455 Tuke St

15 Filed AUG 28 1930

16 Registered

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 26, 1930, that I last saw h[illegible] alive on Aug 25, 1930, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Immaturity

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Thymus Examined

(Signed) W. A. Bibby M. D.

, 19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Moriah Cemetery

DATE OF BURIAL Aug 27 19 30

UNDERTAKER [illegible]

ADDRESS 3455 Tuke St

Spec.—1-30—M. & T.—250 Bks.

E 60074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60074

REGISTERED NO. 27-53 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Woodlawn Road ST.

2-FULL NAME Ella Brock Terwilligar

(a) RESIDENCE NO. St. Augustine, Fla. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Terwilligar

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	11	31	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Joseph Brock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Elmira Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant (Address) Alexander C. Terwilligar Titusville, Fla.

15 Filed AUG 28 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1930, to Aug 27, 1930, that I last saw her alive on Aug 27, 1930, and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Failure — about 2 wks.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma - (breast - operation.) Metastases in liver. (duration) about 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Several yrs ago

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carroll Lockard M.D. 42 E. Preston St

(Address) Aug 27, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Augustine, Fla.

DATE OF BURIAL Aug. 28, 1930

20 UNDERTAKER John O. Mitchell & Sons,

ADDRESS 900 Eutaw Pl

Spec.—1-30—M. & T.—250 Blks.

E 60075

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60075

CERTIFICATE OF DEATH.

REGISTERED NO. 161-002

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (NO. Broadway and Fairmount WARD) 24-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Lorraine Kraft

(a) RESIDENCE NO. 608 Hyson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND) of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/24/30.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Edward Kraft

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabelle Lutsche

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant mother 608 Hyson St.
(Address)

15 Filed 8-28-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/30

17 I HEREBY CERTIFY, That I attended deceased from 8/24, 19 30, to 8/27, 19 30,

that I last saw h[illegible] alive on 8/27, 19 30,

and that death occurred, on the date stated above, at 1A (E.S.T.) m.

The CAUSE OF DEATH* was as follows: Retro-perulonal hemorrhage probably resulting from birth injury

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W R Swartwelder M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leeder Hill

DATE OF BURIAL Aug 28 1930

ADDRESS

20 UNDERTAKER D F McCully 128 E Fort Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60076 31 E 60076

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 808 W. Ostend ST., 7-1-34 (WARD)

2-FULL NAME Lottie Johns Thomas

(a) RESIDENCE NO. 808 W. Ostend ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Col.	married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of William Thomas

6 DATE OF BIRTH (month, day, and year) July 3 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General House work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Leonard Johns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Francis Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William Thomas (Address) 808 W. Ostend St.

15 Filed 2-8 1930 19 Pepe Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24/30

17 I HEREBY CERTIFY, That I attended deceased from 7/6/30, 19..., to 8/24, 1930, that I last saw her alive on 8/23, 1930, and that death occurred, on the date stated above, at 7.20 P.m. E.S.T.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia Acute Bronchitis yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Jones Worley, M. D.

8/25/30 (Address) 1708 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug 28, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3224 Edmondson Ave.

Spec.—1-30—M. & T.—250 Bks.

E 60077

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60077

46

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 14-20 WARD)

2-FULL NAME Anna Wise.

(a) RESIDENCE NO. 637 Morton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Col	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Wise.

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) Md.

PARENTS

10 NAME OF FATHER Gilmore Fraud

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Custis

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md

14 Informant Friends (Address) Baltimore City Hosp.

15 Filed AUG 28 1930 CHAMPE [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24-30

17 I HEREBY CERTIFY, That I attended deceased from 6-26, 1930, to 8-24, 1930, that I last saw h[illegible] alive on 8-24, 1930, and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri

Local metastasis

(duration) Yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical examin

(Signed) Fred M. Duckwall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Lawn Cem. DATE OF BURIAL Aug 28 30

20 UNDERTAKER E. Stansbury ADDRESS Belair

Spec.—1-30—M. & T.—250 Bks.

239944

E 60078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 51 E 60078

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Gray

(a) RESIDENCE NO. 343 Hillen ST- ST., WARD Towson-Ma-

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Child

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md-

PARENTS

10 NAME OF FATHER Nephtan Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga-

12 MAIDEN NAME OF MOTHER Anna Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md-

14 Informant JOHNS HOPKINS HOSPITAL Records-

(Address)

15 Filed AUG 26 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25-30

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1930, to Aug 25- 1930, that I last saw h alive on Aug 25- 1930, and that death occurred, on the date stated above, at 7 05 a.m.

The CAUSE OF DEATH* was as follows:

Rheumatic Carditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Towson, Md.

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) V. C. Goodspeed, M. D.

8/25, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Rest

DATE OF BURIAL Aug 27 1930

ADDRESS 1345 Ashburton

20 UNDERTAKER Mrs. R. G. Elliott

E. C. JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 60079 HEALTH DEPARTMENT—CITY OF BALTIMORE É 60079

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division ST. 10-13 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emeline Adams

(a) RESIDENCE NO. 1421 Barnes ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Unknown 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 0 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Paul Adams
(Address) 1421 Barnes St.

15 Filed 2 8 1930 H. [illegible] JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1930, to Aug. 26, 1930, that I last saw h. alive on Aug 26, 1930, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation
+ dilatation

(duration) 4 to 6 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis (duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Carroll M. S[illegible] Clan, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. DATE OF BURIAL Aug 27 1930

UNDERTAKER Mrs. P. G. Elliott ADDRESS 1320 Ashland Ave

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60080

24-001

E 60080

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST., 7-13 WARD)

2-FULL NAME John White

(a) RESIDENCE NO. 827 N. Dallis ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Sept 7-1882

7 AGE — Years: 48 | Months: 11 | Days: 15 | If LESS than 1 day, hrs. or min.: .....

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Gardner
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Va do

PARENTS

10 NAME OF FATHER: Mack Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Henderson Va

12 MAIDEN NAME OF MOTHER: Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Goldsboro N.C.

14 Informant: Annie Phillips (Address) 827 N Dallis

15 Filed AUG 26 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Sudden

(duration) ..... yrs. ..... mos. .....

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) A. Leslie Falk, M. D. Coroner

(Address) Aug 22nd Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary

DATE OF BURIAL: Aug 29 1930

20 UNDERTAKER: Mrs. R. G. Elliott

ADDRESS: 1225 Eastland

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60031

CERTIFICATE OF DEATH.

31 ✓ E 60031

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 2961 Fredericus av ST., 20-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Miller McCoy Sr

(a) RESIDENCE NO 2961 Fredericus av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen McCoy

6 DATE OF BIRTH (month, day, and year) Aug 29-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry 066

(c) Name of employer D. Gunbarrel Son

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Robert McCoy

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Thomas

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Md

14 Informant Helen McCoy (Address) 2961 Fredericus av

15 Filed AUG 28 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1930, to Aug. 26, 1930, that I last saw him alive on Aug. 23, 1930, and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Henry B. Athey, M. D.

8/27, 1930 (Address) 2504 Druid Park Lake Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Aug 28 1930

20 UNDERTAKER W. J. Frederick Sons ADDRESS Norfolk

Rev—12-23-21—E.B.R.S.—400 Eks.

E 60082 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60082

CERTIFICATE OF DEATH.

Registered No. 15-21 29

1-PLACE OF DEATH

City of BALTIMORE: (No. 1718 N. Fulton Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Washington Beck

(a) Residence No. 1718 N. Fulton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Wh

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Katherine M. Beck

6-DATE OF BIRTH (month, day and year): May 27, 1855

7-AGE: 75 yrs. 3 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Book-keeper 004

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: August Waltham

9-BIRTHPLACE (city or town) (State or Country): Easton, Md

PARENTS

10-NAME OF FATHER: Geo. W. Beck

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Martha J. Matthews

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant): Katherine M. Beck

(Address) 1718 N. Fulton Ave.

15- Filed AUG 28 1930 NAME JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 28, 1930

17- I HEREBY CERTIFY, That I attended deceased from June, 1922 to Aug 28 1930

that I last saw him alive on Aug 28, 1930

and that death occurred, on the date stated above, at 12.10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio - Pneumonia

(Duration) yrs. mos. 12 ds.

CONTRIBITORY (Secondary) Chronic Nephritis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual sign.

(Signed) Geo. E. Wells M. D

19 (Address) 4100 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Easton, Md DATE OF BURIAL: Aug. 30, 1930.

20-UNDERTAKER: Wm. J. Pickner & Son ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—500 Bks.

E 60083

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60083

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Peach St. 12-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Malinda Robinson

(a) RESIDENCE NO. 805 Peach St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Robinson

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 60		?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Smith

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mattie Robinson
(Address) 805 Peach St.

15 Filed ____ 19 C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26/30

17 I HEREBY CERTIFY, That I attended deceased from 8/ , 1930, to 8/26, 1930, that I last saw h[er] alive on Aug 8, 1930 and that death occurred, on the date stated above, at 7:55 P. m.

The CAUSE OF DEATH* was as follows:

Glomerular Nephritis

(duration) ? yrs. ? mos. ! ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) D. H. Hamrick, M. D.

8/27/30 (Address) 830 Shoop St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Aug 28 1930

20 UNDERTAKER C. A. Burns & Son

ADDRESS 1518 W. Mondawmin

Spec.—2-29-28—1. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60084

E 60084

CERTIFICATE OF DEATH

REGISTERED NO. 49

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 W. Belvidere Avenue ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Franklin Stewart Fiske

(a) RESIDENCE NO. 900 W. Belvidere Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Shaw Fiske

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	54	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Owner 017

(b) General nature of industry, business, or establishment in which employed (or employer) Confectioner

(c) Name of employer Self. Baltimore

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles F. Fiske

11 BIRTHPLACE OF FATHER (city or town) (State or country) America

12 MAIDEN NAME OF MOTHER Roberta A. Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Franklin S. Fiske

(Address) 900 W. Belvidere Ave.

Filed AUG 28 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26. 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/2, 1930, to 8/26, 1930, that I last saw him alive on 8/27, 1930 and that death occurred, on the date stated above, at 11:05 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lung

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory tests

(Signed) H. B. Shubert M. D.

8/27, 1930 (Address) 1403 Rank Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL August 29 1930

20 UNDERTAKER McGUIRE COMPANY WOODEN, Successor

ADDRESS 1011 N. Howard St.

Spec.—2-29-28—J. F. S.—500 Bks.

E 60085

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60085

CERTIFICATE OF DEATH

REGISTERED NO. 27-48

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Charles St & Gittings Ave's ST., WARD)

2—FULL NAME Allen Wallace Mason

(a) RESIDENCE NO. Charles St & Gittings Ave's ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Dugan Mason.

6 DATE OF BIRTH (month, day, and year) May-2-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Dr. Allen Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) America.

12 MAIDEN NAME OF MOTHER Mary D. Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Carter George

(Address) 115 W. Lafayette Avenue.

15 Filed AUG 28 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 24, 1930, to August 26, 1930, that I last saw him alive on August 26, 1930 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows: Sarcoma (retro-peritoneal)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of March 3, 30

Was there an autopsy? No

What test confirmed diagnosis? Microscopic section

(Signed) Edwin A Jandell M. D.

, 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL August 28/30

20 UNDERTAKER [illegible] & MOWEN COMPANY (William F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60086 129 E 60086

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

60086

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1017 N. Dallas ST. 9-13 (WARD)

2-FULL NAME Mollie Hoffman

(a) RESIDENCE NO 1017 N. Dallas ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Hoffman

6 DATE OF BIRTH (month, day, and year) March 17/1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	5	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Peter Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Boyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs. Catherine Cavanaugh
(Address) 2120 N. Calvert St

15 Received 8 29 1930 By H. A. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocarditis-Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Walker, M. D. Coroner

8/29/1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Aug 29 1930

20 UNDERTAKER Henry Hoecke Sons Inc

ADDRESS 1201 E Eager St

1-30—M. & T.—100 B—50L

E 60087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 60087

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp STREET 7-57 WARD

2-FULL NAME Haskins Hanover

(a) RESIDENCE NO 515 Cordelia Ave STREET ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Hanover

6 DATE OF BIRTH (month, day, and year): Sept 15-1879

7 AGE — Years: 50 — Months: 11 — Days: 12 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Prop of
(b) General nature of industry, business, or establishment in which employed (or employer): Vulcanizing Shop
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac Hanover

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Isaac —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Fannie (Address) 1439 E Baltimore St

15 Filed 7-28-1930 C. HAMILTON JOHNS, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows*: Accident Fractured Spine & both wrists, Lacerated Mouth

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): fell from Porch

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. H. Quirk, M. D. Coroner

July 29th 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fannie Washington Lod

DATE OF BURIAL: 7-28-1930

20 UNDERTAKER: Not Known

ADDRESS: 1439 E Baltimore St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60088

54 E 60083

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 3-5 WARD)

2-FULL NAME Thomas Butler

(a) RESIDENCE NO. 1011 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-25-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New London (State or country) Conn.

PARENTS

10 NAME OF FATHER Thomas Butler

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Conn.

12 MAIDEN NAME OF MOTHER Jane Leach

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Conn.

14 Records of Informant Baltimore City Hosp. (Address)

15 Filed 8-27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26-30

17 I HEREBY CERTIFY, That I attended deceased from 6-2-30, 19..., to 8-26, 1930, that I last saw him alive on 8-26, 1930, and that death occurred, on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, acute

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

8-27 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 8/28 1930

UNDERTAKER John J. Fahey Sons

ADDRESS 1318 Light St

Spec.—1-30—M. & T.—250 Bks.

E 60089 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60089

CERTIFICATE OF DEATH.

49

REGISTERED NO. 27-55

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5721 Park Heights Ave. (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo W. Friedwnwald

(a) RESIDENCE NO. 5721 Park Heights Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Lena M. Friedwnwald

6 DATE OF BIRTH (month, day, and year) July 9, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Friedenwald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Rosenwald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Lena Friedenwald

(Address) 5721 Park Heights Ave

15 Filed 8 28 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1925, to Aug. 27, 1930, that I last saw h[illegible] alive on Aug. 26, 1930, and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right lung

About 1 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray.

(Signed) Theodore H. Thomson M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem.

DATE OF BURIAL 8/29/ 1930

20 UNDERTAKER Harid. Sandheim & Son

ADDRESS 1902 Eutaw Place

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60090

CERTIFICATE OF DEATH

90 E 60090

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 910 S Wolfe St. 2-4 Ward)

2-FULL NAME Rozalia ~~Helinski~~ Helinski

(a) RESIDENCE NO. 910 S. Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Helinski

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Poland

PARENTS

10 NAME OF FATHER Jakut Blachowicz

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) poland
(State or country)

14 Informant John Helinski Husband
(Address) 910 S Wolfe st

15 Filed 2 8 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 3 yrs. 5 mos. ds.

18 Where was disease contracted If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M. Fenton M. D.

8 27 1930 (Address) 702 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cemetery	Aug 29 1930
20 UNDERTAKER	ADDRESS
George A Weber	701 E Ann

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 6009I

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

74 E 6009I

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 16-37 WARD)

2-FULL NAME Rosie Williams

(a) RESIDENCE NO. no home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEmale	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Records of Baltimore City Hosp.

Informant

(Address)

G 28 1930 C. HARRISON JONES, M. D.

Registrar

Per Reg

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26-30

17

I HEREBY CERTIFY, That I attended deceased from 7-23- , 1930 , to 8-26 , 1930 ,

that I last saw h e alive on 8-26- , 1930 ,

and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension UNKNOWN

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1. Hospital 2 Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

8-26, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 30 1930
20 UNDERTAKER	ADDRESS 3221 Ashland Ave
Mrs. Kate R. Williams	

Spec.—1-30—M. & T.—250 Bks.

E 60092

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60092

CERTIFICATE OF DEATH.

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST., 2-13 WARD)

2-FULL NAME Matilda R. Hebb

(a) RESIDENCE NO. Fort Howard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Thomas L. Hebb.

6 DATE OF BIRTH (month, day, and year) Oct. 27, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Tson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Hanna Hosky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Thomas L. Hebb
(Address) Fort Howard, Md.

15 Filed 2-8-1930 H. HARRY JONES, M. D. Registrar
By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27/1930

17 I HEREBY CERTIFY, That I attended deceased from July 28½, 1930, to Aug. 27, 1930, that I last saw her alive on Aug. 26½, 1930, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis ?
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Archie Robert Colum, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Ct. Va.

DATE OF BURIAL Aug. 28 1930

20 UNDERTAKER John G. Connelly

ADDRESS Essex

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60093

CERTIFICATE OF DEATH.

46 E 60093

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4320 Ready Ave ST. 27-47 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline B. Jang

(a) RESIDENCE No. 4320 Ready Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Fred Jang

6 DATE OF BIRTH (month, day, and year) Sept 4, 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Stephen W. Waldhorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jobanda C. Wiesenay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Husband) J. Fred Jang (Address) 4320 Ready Ave

15 Filed AUG 28 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to Aug 27, 1930, that I last saw her alive on Aug 27, 1930, and that death occurred, on the date stated above, at 7P-m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Multiple Carcinomatosis Uterus & Intestines Feb 1930 & Aug 27/30 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Where?

What test confirmed diagnosis? Laboratory & Clinical

(Signed) J. Wheaton, M. D.

, 19 (Address) 4309 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery DATE OF BURIAL Aug 30 1930

20 UNDERTAKER Elmer W. Conklin ADDRESS 924 E Eager

Spec.—1-30—M. & T.—250 Bks.

E 60094 ✓ E 60094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 9-W Ward)

2-FULL NAME Arundel B Steinfelt Jr.

(a) RESIDENCE No. 638 Cokesbury Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4, 1927

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Arundel B Steinfelt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Cecilia McFobbe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Arundel B Steinfelt Sr.

(Address) 638 Cokesbury St.

15 Filed Aug 29 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/30

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Aug 28, 1930, that I last saw h... alive on Aug 28, 1930, and that death occurred, on the date stated above, at 4 10 m.

The CAUSE OF DEATH* was as follows:

peritonitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? place of death.

Did an operation precede death? yes Date of Aug 7

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) ... M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Aug 30 1930

UNDERTAKER Elmer W. Conklin ADDRESS 424 E Eager St

Spec.—1-30—M. & T.—250 Bks

E 60095 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60095

CERTIFICATE OF DEATH.

REGISTERED NO. 100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Savetman

(a) RESIDENCE NO. 920 E. Baltimore St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 60

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) David Savetman

(State or country) Russia

PARENTS

10 NAME OF FATHER David Savetman

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Kemper

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Russia

14 Informant Records of Baltimore City Hosp.

(Address)

15 Filed AUG 28 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26-30

17 I HEREBY CERTIFY, That I attended deceased from 8-21-30, 19..., to 8-26-, 19 30, that I last saw him alive on 8-26, 19 30, and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Alcoholism, Chronic and acute

(duration) UNKNOWN yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Podgd. M. D.

(Address) 8-28 1930 Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL Aug 28 1930

20 UNDERTAKER L. Levinson Bro.

ADDRESS 1127 E. Balto. St

AUG 28 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60096

CERTIFICATE OF DEATH.

9V E 60096

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 26-37 WARD)

2-FULL NAME Henrietta J Fischer

(a) RESIDENCE NO. 3602 Hudson St ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of John Fischer (husband)

6 DATE OF BIRTH (month, day, and year) Feb. 22nd 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Eibert Mohrfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Doris Wolsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John T. Fischer

(Address) 3602 Hudson St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

AUG 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1930, to Aug 26, 1930

that I last saw h-er alive on Aug 26, 1930

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure following an operation for suspension of uterus. Also Thrombosis mesenteric (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) myocardial failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-25-30

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) W. S. Vinson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetary

DATE OF BURIAL Aug 29th 1930

20 UNDERTAKER Lilly & Zeiler Sr.

ADDRESS 4033 S. Wolfe St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60097

CERTIFICATE OF DEATH

E 60097

REGISTERED NO. 90 E 60097

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 617 S. Clinton St., No. 2 Ward)

2-FULL NAME Elizabeth Frantz

(a) RESIDENCE NO. 617 S. Clinton St., 26 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lawrence Frantz

6 DATE OF BIRTH (month, day, and year) March 21 1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country)

PARENTS

10 NAME OF FATHER John G. Buettner

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Kunigunda Buettner

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Lawrence E. J. Frantz
(Address) 617 S. Clinton St

15 FILED [illegible] Registrar

AUG 28 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) and that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
End Carditis
about
(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) James M Fenton, M. D.
8 27 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Aug 29th 1930
20 UNDERTAKER Lilly + Zeiler Inc	ADDRESS 4038 Woodland

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60098

E 60098

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 S. Rose ST., V-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Backert.

(a) RESIDENCE NO. 610 S. Rose ST., 1 WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew A. Backert

6 DATE OF BIRTH (month, day, and year) April 1888

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Benno Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Schoenholtz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Andrew A. Backert

(Address) 610 S. Rose St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1930, to Aug. 26, 1930

that I last saw h[illegible] alive on Aug. 26, 1930

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis Meningoencephalitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 (Address) 3574 Eastern ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL Aug 30th 1930

20 UNDERTAKER Lilly + Zeiler Inc

ADDRESS 923 S. Wolfe St

AUG 26 1930

Spec—1-30—M. & T.—250 Bks.

E 60099

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 60099

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3417 E. Hamilton ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Tulley

(a) RESIDENCE No. 3417 E. Hamilton ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22 1929

7 AGE: Years 1 | Months 1 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath, (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Tulley

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Charles Tulley (Address) 3417 E. Hamilton ave

15 Filed AUG 8 1930 Registrar C. HARRY JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1930, to Aug 26, 1930, that I last saw h[illegible] alive on Aug 26 1930, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fushin, M. D.

(Address) 1823 N. Rosel St, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery DATE OF BURIAL Aug 29 1930

20 UNDERTAKER: Fred L. Leas & Son ADDRESS 7401 Belair Rd.

Spec.—1-30—M. & T.—250 Bks

E 60100 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 60100

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4232 Belmar Ave. ST. 26-42 WARD)

County: Mrs. Anna M. Schuster

2-FULL NAME

(a) RESIDENCE NO. 4232 Belmar Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE~~ of: Joseph R. Schuster

6 DATE OF BIRTH (month, day, and year): March 10 1864

7 AGE: Years 61 | Months 5 | Days 17 | If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Knoerr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Hark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): family 4232 Belmar ave.

15 Filed 2 8 1930, 19 MARION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Aug 27, 1930, that I last saw her alive on Aug. 27, 1930 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Recurrence of adeno-carcinoma Sm right stump & broad ligament

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Uremic Coma due to pressure on ureter

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic examination Oct 1927

(Signed) John Connor M. D.

, 19 (Address) Belmar ave & Belly.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem.

DATE OF BURIAL: Aug 30th 1930

20 UNDERTAKER: E & B Hark

ADDRESS 115 E. West St.

Spec.—1-30—M. & T.—250 Bks.

239877
E 60101

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 E 60101

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 21-29 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Quinn

(a) RESIDENCE NO. 731 W. Barre ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of William Quinn

6 DATE OF BIRTH (month, day, and year) Nov-10-1902

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or .....min.
	27	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dressmaking
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Ullenreither
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Margaret Kane
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)
Filed AUG 28 1930 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-26-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Aug 26, 1930, that I last saw her alive on Aug 26, 1930, and that death occurred, on the date stated above, at 8 27 P. m.

The CAUSE OF DEATH* was as follows:
Acute Salpingitis (probably gonococcal)
Acute generalized peritonitis
(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Time (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes Date of Aug 15 1930 (Appendectomy & drainage)
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy - Smears
(Signed) H. S. Everett, M. D.
8/26, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn
DATE OF BURIAL 8/29, 1930
20 UNDERTAKER William Cook
ADDRESS 1217 E. Baltimore St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60102 129 E 60102

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1629 Webster St. 24-24 (Ward)

2-FULL NAME James E. Willis

(a) RESIDENCE NO. 1629 Webster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Louisa Willis

6 DATE OF BIRTH (month, day, and year) Apr 29th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Diamond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Louisa Willis

(Address) 1629 Webster St

15 Filed [illegible] 19 [illegible] Registrar

AUG 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930 to Aug 26, 1930

that I last saw ~~him~~ alive on Aug 26, 1930

and that death occurred, on the date stated above, at 11 50 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs 6m mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine +++

(Signed) Dan Drannen M. D.

8/27 1930 (Address) 122 — St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 8/30/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60103

CERTIFICATE OF DEATH

REGISTERED NO. 129 E 60103

1—PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No.) Madison & Linden ST. (WARD) 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Charles N. Browning

(a) RESIDENCE NO. Darlington Md ST., WARD Darlington. Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs. Charles N. Browning

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Owner

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Charles N Browning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Olivia Muncie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital record
(Address)

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

AUG 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 27 - 30

17 I HEREBY CERTIFY, That I attended deceased from August 27, 1930, to aug 27, 1930, that I last saw h alive on aug 27, 1930 and that death occurred, on the date stated above, at 9 25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert V Chenowith, M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Darlington Cem DATE OF BURIAL Aug 30, 1930

UNDERTAKER B. C. Hoch ADDRESS 1000 S. Race St

1-30—M. & T.—100 B—50L

E 60104

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60104

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1418 Barnes ST. 10-13 (WARD)

2-FULL NAME John T. Wilson

(a) RESIDENCE NO 1418 Barnes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	black	~~Mar~~ Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Wilson

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Ella Doyer

(Address) 1603 Madison Ave

15 [illegible] 28 1930 19[illegible] C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Myocarditis & Valvulitis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) History of injury of dorsal & lumbar spine (duration) 10-12 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? "opkins Records

(Signed) [illegible] Coroner, M. D.

8/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel [illegible] Cemetery	August 19 3[illegible]

20 UNDERTAKER [illegible] Geo. H Holland ADDRESS 1631 [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60105 — 44 E 60105

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 444 Loraine Ave ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane E Clark

(a) RESIDENCE NO. 444 Loraine ST. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Madden Clark

DATE OF BIRTH (month, day, and year) 5-3-1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain Fire Dept

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs C Clark

(Address) 444 Loraine Ave

15 Filed AUG 28 1930, 19 THAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to Aug 24, 1930, that I last saw h.. alive on Aug 24, 1930 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach, gall bladder and liver

(duration) — yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? Yes Date of July 7, 1930.

Was there an autopsy? No.

What test confirmed diagnosis? Inspection + Tissue exam.

(Signed) Frank H. Ogden, M. D.

, 19 (Address) 2701 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Aug 29 1930

20 UNDERTAKER Mary M Wedefeld — ADDRESS 501 E 22nd

Spec.—8-16-29—L. F. S.—100 Bks.

E 60106 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60106

CERTIFICATE OF DEATH + 129

REGISTERED NO.

1—PLACE OF DEATH Baltimore, Md. U.S. Marine Hospital

CITY OF BALTIMORE: (No. 12-51 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Holliday

(a) RESIDENCE NO. Petersburg, Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) So. Carolina

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) So. Carolina

12 MAIDEN NAME OF MOTHER Mary Ballard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) So. Carolina

PARENTS

14 Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

Filed 2 8 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to August 27, 1930, that I last saw him alive on August 29, 1930, and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, parenchymatous, acute (probably an acute exacerbation of chronic Nephritis)

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia, chronic

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) Gordon A. Abbott, M. D.

8/28 1930 (Address) U.S. Marine Hospital, Balto., Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sumter S.C.

DATE OF BURIAL Aug 28 1930

UNDERTAKER Harry Nuckols

ADDRESS 414 Edmonds

Spec.—1-30—M. & T.—250 Bks.

E 60107 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60107

CERTIFICATE OF DEATH.

100-00

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Kingsmore.

(a) RESIDENCE NO. 531 Brunswick St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary A. Kingsmore.

6 DATE OF BIRTH (month, day, and year) March 12 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 23

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Driver.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Kingsmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Emma Hartley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Mary A. Kingsmore

(Address) 531 Brunswick St.

Filed Aug 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 , 19 30, to Aug 27 , 19 30, that I last saw him alive on Aug 27 , 19 30, and that death occurred, on the date stated above, at 1:30 p m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

Delirium Tremens - sec. to Pneumonia. and of 3 days Duration

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Myocarditis interstitial

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of abode

Did an operation precede death? No Date of -

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy - Clinical data

(Signed) Geo Fraser, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery. DATE OF BURIAL Aug. 29 1930.

20 UNDERTAKER Charles J. Schwab ADDRESS 505 N. Monroe St.

Spec. 2-29-28—L. F. S.—500 Bks.

E 60108

HEALTH DEPARTMENT—CITY OF BALTIMORE

E/60103

CERTIFICATE OF DEATH

57

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 John ST. 14-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie H. Morgan

(a) RESIDENCE NO. 1510 John ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Randolph Morgan

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At. Home

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

10 NAME OF FATHER John T. Stocksdale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll County Maryland

12 MAIDEN NAME OF MOTHER Annie E.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County Maryland

PARENTS

14 Informant Mr. Harold R. Morgan

(Address) 1510 John St.

15 Filed 8 29 1930 C. HAMPSON JONES, M. D. Registrar

Ref.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/23, 1930, to 8/27, 1930, that I last saw her alive on 8/27, 1930, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) Probably many yrs. mos. ds.

CONTRIBUTORY (Secondary) Facial Erysipelas (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Harold Morgan, M. D.

8/28, 1930 (Address) 1408 Park Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Aug. 30 1930

20 UNDERTAKER Harold Cook

ADDRESS 1003 West Baltimore St.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

103

E 60109

CERTIFICATE OF DEATH

E 60109

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No.) 1000 Eaton Ave ST., WARD 12-50

2-FULL NAME William T. Gilmore

(a) RESIDENCE NO. 2640 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) July 14th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas S. Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Gilchrist

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co Md

14 Informant Jenkins Memorial (Address)

15 Filed ... 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to Aug 28, 1930,

that I last saw h[illegible] alive on Aug 28, 1930,

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) [illegible] M. D.

(Address) Jenkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL Aug 30 1930

UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh & Richards

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60110 31 E 60110

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S Ewly ST., 6 WARD)

2-FULL NAME Nicholas Zampini

(a) RESIDENCE NO. 520 S Ewly ST. 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Zampini

6 DATE OF BIRTH (month, day, and year) Mar 25 1894

7 AGE Years 36 Months 9 Days 3 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Felix Zampini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Femenilo Amore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Theresa Zampini

(Address) 520 S Ewly St

C. HAMPSON JONES, M. D.

AUG 29 1930 19 11 A.M. P.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1929 to Aug 28 1930.

that I last saw h alive on Aug 28 1930

and that death occurred, on the date stated above, at 5 p m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos 28 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1013 Lamdin

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical diagnosis

(Signed) I J Silverhood M. D.

8/29/30 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem DATE OF BURIAL Sept 1 1930

20 UNDERTAKER Martin W E Dippel ADDRESS 37 S Ann St

Spec.—1-30—M. & T.—250 Bks.

E 60111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-9 E 60111

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Good Husband Hosp ST. 18-26 (WARD)

2-FULL NAME Dorothy Allen

(a) RESIDENCE NO. 1113 W. Franklin ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C.	S

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	2	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS
10 NAME OF FATHER Melvin Allen
11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)
12 MAIDEN NAME OF MOTHER Lucille Weston
13 BIRTHPLACE OF MOTHER (city or town) N. C
(State or country)

14 Informant Lillian Higgins
(Address) 106 N. Glover Ave

15 Filed AUG 29 1930 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/30

17 I HEREBY CERTIFY, That I attended deceased from 8/25 1930 to 8/28 1930,
that I last saw h[illegible] alive on 8/27th 1930,
and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:
Septic Meningitis.
(duration) yrs. mos 3 ds.
CONTRIBUTORY (Secondary) Otitis Media
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 1113 W. Franklin
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? Clinical Tests

(Signed) J. T. Dunn, M. D.
19 (Address) 522 N. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery — DATE OF BURIAL Aug 31 1930

UNDERTAKER Wm. H. Elliott Sons — ADDRESS 1100 Madison

Cor.—12-9-25—A Co—200 Bks.

E 60112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 188 001 E 60112

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balt City Hosp St. 16-37 Ward

2-FULL NAME John Hassell

(a) RESIDENCE NO. Dundalk Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-19 1907

7 AGE: Years 23 Months 7 Days 8 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ?

(State or country) West Indians

PARENTS

10 NAME OF FATHER Richard Hassell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) West Indians

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) West Indians

14 Informant Henry J. Hassell

(Address) 1062 Bergen St Brooklyn NY

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29-30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows: Auto in which he was riding struck & mashed

(a) CONTRIBUTORY (Secondary) Fract Skull (duration) ..... yrs. ..... mos. ..... ds.

(b) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Traut M. D.

(Coroner)

8-29-30 (Address) 7934 Ant Elden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where did disease contracted, if not at place of death? Dundalk

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Buchmans Date of Burial 8/30 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul

29 1930

very important. See instructions on back of certificate.

Spec.—1-12-23—A&T—500 Bks.

E 60113 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60113

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp ST. 9-9 WARD)

2-FULL NAME Charles Anderson

(a) RESIDENCE NO. 1630 Jefferson ST., WARD Woods Island Fla

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Anderson

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: Years 42; Months; Days; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: David Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Ballard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Anderson (Address) 1630 Jefferson St

15 Filed AUG 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/26. 1930.

17 I HEREBY CERTIFY, That I attended deceased from 8/21, 1930, to 8/26, 1930, that I last saw him alive on 8/26, 1930 and that death occurred, on the date stated above, at 5.50 pm

The CAUSE OF DEATH* was as follows:

Chronic Glomerulo-nephritis

(duration) unknown mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death?, at home

Did an operation precede death? No Date of

Was there an autopsy? Yes. What test confirmed diagnosis? Clinical Autopsy

(Signed) Hagaman, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dear Island Fla DATE OF BURIAL: aug 29 1930

20 UNDERTAKER: Edward Bryan ADDRESS 1631 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60114

CERTIFICATE OF DEATH

31

E 60114

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Maryland Penitentiary ST., (WARD) 954 Forrest 10-15

2—FULL NAME Herman Brodie

(a) RESIDENCE NO. 954 Forrest ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 11 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5, 1897

7 AGE — Years: 32 | Months: 11 | Days: 20 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer & Teamster

(b) General nature of industry, business, or establishment in which employed (or employer): Md. Pen'y

(c) Name of employer: State

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Brodie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Rosa Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Md

14 Informant: Bessie Buckley

(Address): 806 N. Lexington St

15 Filed Dec 2, 1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to Aug 25, 1930

that I last saw him alive on 8-22 pm Aug 25, 1930

and that death occurred, on the date stated above, at 10 55 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of both lungs

(duration) 4 yrs. 2 mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum Test

(Signed) Humph. Thomas Jr, M. D.

. 19 (Address) 120 W. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Aug 30, 1930

20 UNDERTAKER: Mrs. Kate R. Wilkins

ADDRESS: 311 N Schroeder St

Spec.—1-30—M. & T.—250 Bks

60115

HEALTH DEPARTMENT—CITY OF BALTIMORE

60115 E

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 W Franklin St. 19-27 WARD)

2-FULL NAME Hattie Brooks

(a) RESIDENCE No. 1607 W Franklin St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Brooks

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	+	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Days Work

(b) General nature of industry, business, or establishment in which employed (or employer) 0'0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexander Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James Brooks (Address) 1607 W Franklin

15 Filed ..... 19 ..... JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/30

17 I HEREBY CERTIFY, That I attended deceased from 8/13, 1930, to 8/27, 1930, that I last saw h alive on 8/26, 1930 and that death occurred, on the date stated above, at 12 o'clock m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma following Cancer of Breast

(duration) — yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Jan - 1930

Was there an autopsy? no

What test confirmed diagnosis? Johns Hopkins

(Signed) Dan Brandenburg M. D.

8/27/1930 (Address) 122 W Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug 31, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

Spec. 7-17-26—A Co.—200 Bks.

Elmer E Zepp

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60116

E 60116

CERTIFICATE OF DEATH

REGISTERED NO. 24-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 6317 Wallis Ave. St. 27-35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer E. Zepp

(a) RESIDENCE NO. 6317 Wallis Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 1873 - 1873

7 AGE Years: 56 Months: 8 Days: 27

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Carroll Co

(State or country) Maryland

PARENTS

10 NAME OF FATHER Ezra Zepp

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Hahn

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant Mrs Ella M Zepp

(Address) 6317 Wallace Ave Balto

15 Filed 2 9 1930 C. HAMPSON JONES, M. D. Registrar

By LRC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1930 Aug. 27

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1930, to Aug. 27, 1930, that I last saw h[illegible] alive on Aug 27, 1930, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Generalized arterio-sclerosis (duration) unknown yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) K. B. Boyd, M. D.

. 19 (Address) 1040 Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Valley. md

Date of Burial: aug 30 1930

20 UNDERTAKER: H Bankard & Son

ADDRESS: Westminster md

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

60117

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 60117

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1625 Baker St. St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... George Coleman

(a) Residence No. 1625 Baker Street St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married.

6-DATE OF BIRTH (month, day and year) 54 yrs. ago

7-AGE.	If LESS than 1 day.
57 yrs. ... mos. ... ds.	... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS

10-NAME OF FATHER. Milton Coleman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Laura Hopwell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

11- (Informant) Mrs. Lottie Coleman Foster

(Address) 1625 Baker Street

15- Filed ..... 192 ..... Registrar.

29 1930 C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 27/30.

17- I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Aug 27, 1930, that I last saw him alive on Aug 27, 1930, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Diseases Valvular

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Diseases

(Duration) ... yrs. 1 mos. ... ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Chamberlain Symptoms

(Signed) C. B. Flowers, M. D.

Aug 28, 1930 (Address) 914 S. Mary Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Calvary Cy	Aug 31, 1930
20-UNDERTAKER.	ADDRESS.
Mrs. P. G. Elliott	1125 Eastlander

Spec.—1-30—M. & T.—250 Blks.

E 60118 E 60118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 74001

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1518 W. Lanvale ST. 16-22 WARD)

2-FULL NAME Mary Hines

(a) RESIDENCE NO. 1518 W. Lanvale WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jessie Hines.

6 DATE OF BIRTH (month, day, and year) January 1884

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Stewart Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Fannie Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Elizabeth Smith

(Address) 1518 W. Lanvale St.

Filed JUL 29 1930 THAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/30

17 I HEREBY CERTIFY, That I attended deceased from 7/21, 1930, to 7/26, 1930; that I last saw h[illegible] alive on 7/25, 1930, and that death occurred, on the date stated above, at 5 9. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Pigott, M. D.

7/27 1930 (Address) 1536 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Aug 29 1930

20 UNDERTAKER Mrs. R. G. Elliott.

ADDRESS 1229 Eastlundale

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60119

CERTIFICATE OF DEATH

X-188 1001

E 60119

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hosp. St. 06-37 (Ward)

2-FULL NAME Frederick A. Hassell

(a) RESIDENCE NO. Furnus Station St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 1 mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Hassell

6 DATE OF BIRTH (month, day, and year): Dec. 17/83

7 AGE: Years 46 | Months 8 | Days 10 | If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Engineer 30
(b) General nature of industry, business, or establishment in which employed (or employer): Standard Oil Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sava West Indies

PARENTS

10 NAME OF FATHER: John Hassell

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Indies

12 MAIDEN NAME OF MOTHER: Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Indies

14 Informant (Address): Nellie Hassell Furnus Station

Filed 19 HARRY JONES, M. D. Registrar

AUG 29 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto which he was duty Caused with trans

@ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dundalk

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) H. J. Frame, M. D.

8/29 1930 (Address) 2939 W. Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem.

DATE OF BURIAL: 8/30 1930

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60120

182

CERTIFICATE OF DEATH

E 60120

REGISTERED NO. 24435

1-PLACE OF DEATH Found floating in the water at Sutter St. Ward

City of Baltimore: (No. Refinery Wharf Foot of Woodall St., St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
About 40	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found August 24, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning
Probably accidental.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto Leonhardt M. D.
8/28. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

Commissioner of Health.

Important. See instructions on back of certificate.

AUG 2 1930

AUG 28 1930

Per. Wm. H. Woodall

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60121

CERTIFICATE OF DEATH.

× 188-001 E 60121

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 4 7 (Ward)

2-FULL NAME Charles Scruggs

(a) RESIDENCE NO. Times Station Balto Co St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Scruggs

6 DATE OF BIRTH (month, day, and year)

7 AGE: 39 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Wm Scruggs

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): (illegible)

(State or country)

14 Informant: B. Scruggs

(Address): Times Stat

15 Filed_____ 19____ Registrar

JUL 29 1930

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21-30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull & Partially

sub (Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

during yrs. mos. ds.

(Signed) C. W. Kelly M. D.

(Coroner)

Jul 29, 1930 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lapsonatt's Va Date of Burial: July 30

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS: Pikesville

Spec.—1-30—M. & T.—250 Bks

E 60122 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60122

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Williams

(a) RESIDENCE NO. 1623 St. Josephs St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ? (State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records of Baltimore City Hosp. (Address)

15 Filed AUG 29 1930 Registrar C. C. JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25-30

17 I HEREBY CERTIFY, That I attended deceased from 8-1-29, 19..., to 8-25, 1929, that I last saw him alive on 8-25, 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of central Nervous system.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage into Cerebrum (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Wasserman; exam.

(Signed) Paul Padget, M. D.

8-28, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS AUG 29 1930

E. K. WOODALL

Spec.—1-30—M. & T.—250 Bks

E 60123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

REGISTERED NO. E 60123

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 22-30 WARD)

2-FULL NAME William Chase

(a) RESIDENCE NO. 103 York Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-11-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Jim Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica

12 MAIDEN NAME OF MOTHER Lillie Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Records of Balti ore City Hosp. (Address)

15 Filed 29 1930, 19 Registrar JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25-30

17 I HEREBY CERTIFY, That I attended deceased from 8-23, 19 30, to 8-25, 19 30, that I last saw him alive on 8-25, 19 30, and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency.

more than (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic more than (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination.

(Signed) Paul Padget, M. D.

8-28, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS AUG 29 1930

P&F WM. K. WOODALL

Spec.—1-12-23—M&T—500 Blks.

E 60124

HEALTH DEPARTMENT—CITY OF BALTIMORE

131 E 60124

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. Gen Hosp (WARD) 28-64

2-FULL NAME Jacob J. Sweetman

(a) RESIDENCE NO. 4415 Alabama Ave ST., WARD

(Usual place of abode) Hillsdale, Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elva D Sweetman

6 DATE OF BIRTH (month, day, and year) July 17 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cable Splicer

(b) General nature of industry, business, or establishment in which employed (or employer) For C+P Telephone Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wichita Va

PARENTS

10 NAME OF FATHER Samuel M Sweetman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Katherine Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant (Address) Mrs Charles K Sweetman 2041 Harlem Ave

15 Filed 9 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1930

17 I HEREBY CERTIFY, That I attended deceased from July 30 1930 to Aug. 27 1930.

that I last saw h[illegible] alive on Aug. 27 1930

and that death occurred, on the date stated above, at 7.10 pm

The CAUSE OF DEATH* was as follows:

Congenital Polycystic Kidneys

(duration) congenital mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H Ashman, M. D.

, 19 (Address) West Balto. Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Aug 30 1930

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

Spec.—1-30—M. & T.—250 Bks.

E 60125 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60125

11-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. 24-33 WARD)

2-FULL NAME Leland Houghtelings Jr

(a) RESIDENCE NO. 1209 Dust ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 9 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md

PARENTS

10 NAME OF FATHER Leland Houghtelings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lillie V Winkleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mr Leland Houghtelings
(Address) 213 Fontaine Ave

15 Filed 9 1930, 19 Mar C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-21-30, 19..., to 8-29-, 19 30, that I last saw h— alive on ~~on~~ 8-29-, 19 30, and that death occurred, on the date stated above, at 10.50 A m.

The CAUSE OF DEATH* was as follows:

Influenzal Meningitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) MB Cadbury M. D.

8/29, 1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Sept 1 1930

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C 60126 169 E 60126

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hanover St. Bridge. St. 8-12 Ward)

2-FULL NAME Grover J. Hoblitz.

(a) RESIDENCE NO. 2116 E. Biddle St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 10 mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 4 1910

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	19	10	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Grover C. Hoblitz.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Mary Hayman.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mary Rattenhauser. (mother)
(Address) 2116 E. Biddle St.

AUG 29 1930 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Suicide while mentally deranged.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto H. Kennard, M. D.

8/29, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 8/31 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 Eutaw

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 60127 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 57 E 60127

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Scott ST. 21-24 WARD)

2-FULL NAME Charles T. Mitzger

(a) RESIDENCE NO. 1229 Scott ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mitzger

6 DATE OF BIRTH (month, day, and year) 2-11-58

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balt. City

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John G. Mitzger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Mitzger. (Address) 1229 Scott

15 Filed 29 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 19 23, to Aug 28, 19 30,

that I last saw h alive on Aug 28, 19 30,

and that death occurred, on the date stated above, at 5 20 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

about
(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. T. Seabury, M. D.

Aug 29, 19 30 (Address) 636 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 8/30/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

CLARENCE JONES, M. D.

1-30—M. & T.—100 B—50L

E 60128

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-00

E 60128

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST. 27-44 (WARD)

2-FULL NAME Josephine Merendino

(a) RESIDENCE NO 4804 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pietro Merendino

6 DATE OF BIRTH (month, day, and year) Jan 28/1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Saml. Brommerito

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant John Merendino
(Address) 4808 Belair Road

15 Filed 8 29 1930, 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Subsequent fall & fracture of skull (duration) yrs. mos. 12 da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital Report

(Signed) [signature] Coroner, M. D.

8/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 8 30 1930

20 UNDERTAKER [signature]

ADDRESS 1217 E Pratt St

1-30—M. & T.—100 B—50L

E 60129

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60129

CERTIFICATE OF DEATH

REGISTERED NO. 24-33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto Gen Hosp. (WARD) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt H Phillips

(a) RESIDENCE NO 19 Dorsten Pikesville Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Early Phillips

6 DATE OF BIRTH (month, day, and year) 1-20-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robt H Phillips

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Millman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Margret E Phillips

(Address) 19 Dorsten Ave Pikesville Md

15 [illegible] 192 [illegible] Registrar

9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto he was driving collided with market wagon (from rear) & another Auto

(a) (duration) yrs mos ds.

CONTRIBUTORY (Secondary) Fract Skull (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Annapolis Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Shaw Elderdice M. D. Coroner

29, 1930 (Address) 2939 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Garden Lake Cemetery DATE OF BURIAL 8/30 1930

20 UNDERTAKER Frank H. Neural ADDRESS Pikesville Md

Spec.—2-29-28—L. F. S.—500 Bks.

E 60130

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

194 E 60130

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andy Kocur

(a) RESIDENCE NO. 813 S. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Kocur

DATE OF BIRTH (month, day, and year) Nov. 25, 1895

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	10	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Beth. Steel Corp.

BIRTHPLACE (city or town) (State or country) Cleco Slovakia

10 NAME OF FATHER Joseph Kocur

11 BIRTHPLACE OF FATHER (city or town) Cleco Slovakia (State or country)

12 MAIDEN NAME OF MOTHER Anna Unknown

13 BIRTHPLACE OF MOTHER (city or town) Slovakia (State or country)

14 Informant Hospital Records

(Address)

15 [illegible] 19 RRR Registrar

91930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28/1930

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1930, to August 28, 1930.

that I last saw him alive on August 28 1930

and that death occurred, on the date stated above, at 2.25 A. m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Beth. Steel Corp.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Robert L. Chenault, M. D.

. 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Sept 1 1930

20 UNDERTAKER Frank Brochon Son 1906 E Baltimore ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 60131

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60131

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 511 Rock Glen Rd ST.) (WARD) 25-71

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Agnes Bish

(a) RESIDENCE. NO. 511 Rock Glen Rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Silas M. Bish

6 DATE OF BIRTH (month, day, and year) Jan. 20 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Maryland

PARENTS

10 NAME OF FATHER Joshua Crowel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Susanna Everly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Sterling T. Snyder (Address) 511 Rock Glen Rd. Pikesville Md

15 Filed AUG 29 1930 G. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23. 1930. to Aug. 29. 1930.

that I last saw her alive on Aug. 29 1930.

and that death occurred, on the date stated above, at 12:00 noon

The CAUSE OF DEATH* was as follows:

Chronic hypertension cardio-renal disease

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. S. Dippell, M. D.

, 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druiders-Westminster Md DATE OF BURIAL Aug 31 1930

20 UNDERTAKER H Bankard & Son ADDRESS Westminster Md

Spec.—1-30—M. & T.—250 Bks

E 60132 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60132

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 26-34 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs William H. Snodgrass (Annie Snodgrass)

(a) RESIDENCE NO. ST., WARD Delta, Penn

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. William H. Snodgrass

6 DATE OF BIRTH (month, day, and year) April 3, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, 13 hrs. or 20 min.
46	46	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER M O Channing

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Susan Cooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Mr. William H. Snodgrass

(Address) Delta, Penn

Filed Aug 29 1930, 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1930, to Aug. 29, 1930, that I last saw h.. alive on Aug. 29, 1930, and that death occurred, on the date stated above, at 1.25 p.m. (Daylight Saving)

The CAUSE OF DEATH* was as follows:

Cerebello Pontine Tumor

(Acoustic neurofibroma)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Persistent Vomiting (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Delta, Penn

Did an operation precede death? Yes Date of July 14, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Microscopic Exam

(Signed) Samuel McLanahan, M. D.

Aug 29 1930 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta Pa — DATE OF BURIAL Sept 1 1930

20 UNDERTAKER W P Harkins — ADDRESS Delta Pa

Spec.—1-30—M. & T.—250 Bks

E 60133 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60133

92

CERTIFICATE OF DEATH.

REGISTERED NO. 26-36

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6569 (ave) St. Helena ST., (WARD) 26

2-FULL NAME Mary M. Mathaney

(a) RESIDENCE NO. 6569 St. Helena ST., Ave WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Daniel W. Mathaney

6 DATE OF BIRTH (month, day, and year) April 23 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or, employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles D. Kubach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs. Harry R. Mathaney 3300 E. Balto. St.

15 Filed AUG 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27, 30

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1930, to Aug 27, 1930, that I last saw her alive on Aug 27, 1930, and that death occurred, on the date stated above, at 1-15 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. W. Reier, M. D.

8-27, 1930 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn

DATE OF BURIAL Aug 30, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St.

Spec.—1-30—M. & T.—250 Bks.

E 60134 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 60134

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 42-30 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME John J. Crist

(a) RESIDENCE NO. 1062 W Conway ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Crist

6 DATE OF BIRTH (month, day, and year) July 8, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco Co.

(c) Name of employer ?

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Crist

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Rodewald

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Rumt (Address) Baltimore City Hosp.

15 Filed 9 1930 C. HAMPSON JONES, M. D., Registrar. By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-28-30

17 I HEREBY CERTIFY, That I attended deceased from 7-25, 1930, to 8-28, 1930, that I last saw him alive on 8-28, 1930, and that death occurred, on the date stated above, at 6-50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach with local metastasis

(duration) ..... mos. .....

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings

(Signed) Fred W. Duckworth, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL 8/30/30

20 UNDERTAKER J. A. Inoras ADDRESS 3000 Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60135

198 E 60135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital 14-20 Ward)

2-FULL NAME Lula Michel

(a) RESIDENCE NO. 1521 McCulloth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roy Michel

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Harris

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Alice Boone

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. Grace Mason
(Address) 950 Bennett Place

15 Filed 2 9 1930 C. HAMPSON JONES, Registrar By

Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
General Peritonitis due to stab wound of abdomen
Homicide. Stabbed with pocket-Knife (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 1300 Block N Carey St.
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Eugene Fellers, M. D.
8/28. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Barstow Calvert Co Md

DATE OF BURIAL Aug 31 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1307 Eastern Ave

Spec.—1-30—M. & T.—250 Bks

E 60136 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 E 60136

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 17-24 WARD)

2-FULL NAME Wm. Brown

(a) RESIDENCE NO. 1108 Penn. Ave. ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 38 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Brown

6 DATE OF BIRTH (month, day, and year) 12-15-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) South River
(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Sway

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant (Address) Records of Baltimore City Hosp.

15 Filed 8 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-28-30

17 I HEREBY CERTIFY, That I attended deceased from 8-26- , 19 30 , to 8-28 , 19 30 ,
that I last saw him alive on 8-28 , 1930 ,
and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:
Syphilis of aorta with
Aortic insufficiency
(duration) more than yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic
(duration) more than yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Paul Dodgt. M. D.

8-29 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cem.

DATE OF BURIAL Sept 1 1930

20 UNDERTAKER John H Owen

ADDRESS 538 Baltimore St

Spec.—1-30—M. & T.—250 Bks.

E 60137 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 47 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia B. Dennis

(a) RESIDENCE NO. 619 E Biddle St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of But Dennis.

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) New Jersey

PARENTS

10 NAME OF FATHER Geo. Bennett

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) N. J.

12 MAIDEN NAME OF MOTHER Emily Harriett

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Pa.

14 Informant Records of Baltimore City Hosp. (Address)

15 Filed 2 9 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-19, 1930, to 8-29, 1930, that I last saw h[illegible] alive on 8-28, 1930, and that death occurred, on the date stated above, at 5-40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach with metastasis to liver

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings

(Signed) Fred M. Dudley, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Princeton N. J.	Aug 30 19 30
20 UNDERTAKER	ADDRESS
John E. Linder	2435 E Alsop

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60138

CERTIFICATE OF DEATH.

E 60138

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 20-69 Ward)

2-FULL NAME ~~Mrs B~~ Herman Bates

(a) RESIDENCE NO. 3438 Fauna St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine A. Bates

6 DATE OF BIRTH (month, day, and year): Nov 29th 1889

7 AGE: Years 40 Months 8 Days 29 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): Safety Carloader

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER N. Bates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Wunder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. E. Bates 3438 Fauna St.

15 Filed ..... 19.. Registrar

C. THOMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22. 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Contraction

Syn hours (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) W. Straus M. D.

(Coroner)

Aug 29, 1930 (Address) 1039 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial Aug 30/30

20 UNDERTAKER F. S. Wagner ADDRESS 1850 N. Gilmore

very important. See instructions on back of certificate.

R 0 1930

Spec.—1-30—M. & T.—250 Bks.

E 60139

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60139

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Waters

(a) RESIDENCE NO. 125 N Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Waters

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Balto

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Waters

11 BIRTHPLACE OF FATHER (city or town) Eastern Shore (State or country) Md

12 MAIDEN NAME OF MOTHER Lair Gale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Worrell (Address) 125 N. Chapel St

Dec 30 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/30

17 I HEREBY CERTIFY, That I attended deceased from 7-9, 1930, to 8-28, 1930, that I last saw h[illegible] alive on 8-28, 1930, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Hypertension and Cerebral Apoplexy

(duration) [illegible] yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Lung Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

8/31, 1930 (Address) 38 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Crem.

DATE OF BURIAL 8-30 1930

20 UNDERTAKER Byron & Wright

ADDRESS 1218 McElderry St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60140 | 31 | E 60140

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) En route to University Hospital (Sq.) (Ward)

2-FULL NAME Daniel Williams

(a) RESIDENCE NO. 744 W. Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Track Walker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O. R. R. Co

9 BIRTHPLACE (city or town)
(State or country) S. C.

PARENTS

10 NAME OF FATHER John Wm Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Nancy Coleman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. C.

14 Informant Mrs Fay Stuart
(Address) 744 W. Mulberry St

15 8/30 1930 19 C. HAMPSON JONES, M. D. Registrar

For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemoptysis, probably due to Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

8/29. 1930. (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Williamsboro S.C.	Aug 30, 30
20 UNDERTAKER Samuel Stensley	ADDRESS 578 Bdwy

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60141

CERTIFICATE OF DEATH

185 E 60141

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 16-37 Ward)

2-FULL NAME William Marsh

(a) RESIDENCE NO. 629 S. Eden Eaton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie M Marsh

6 DATE OF BIRTH (month, day and year) June 22 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Self 015
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England

PARENTS

10 NAME OF FATHER Unknown Marsh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England ?

14 Informant Wm T. Gephardt
(Address) 620 Selby Rd.

15 [illegible] 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture R Side of Skull
& Extensive Laceration of
Brain Accident from fall down
Stairs in this Home (duration) yrs. mos. 1 hr. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 629 S Eaton

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James M Fenton M. D.

8 29 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Aug 31 1930

20 UNDERTAKER George W. Zickler

ADDRESS 1737 E. Eager St.

Important. See instructions on back of certificate.

30 1930 C. HARRISON JONES, M. D. Registrar

Spec.—1-30—M. & T.—250 Bks.

E 60142

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60142

CERTIFICATE OF DEATH.

REGISTERED NO. 92 E 60142

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2021 Frederick (St.) 20 28 (WARD)

2-FULL NAME John Schwab Jr

(a) RESIDENCE NO. 2021 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Schwab

6 DATE OF BIRTH (month, day, and year) Oct 29-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Harness Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Catonsville Md.

PARENTS

10 NAME OF FATHER John Schwab Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry F Schwab

(Address) 2021 Frederick Ave

15 Filed 0 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28/1930

17 I HEREBY CERTIFY, That I attended deceased from Aug-22, 19 28, to Aug 27, 19 30,

that I last saw him alive on Aug 27, 19 30,

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Hypostatic Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fractured Hip right due to accident (duration) 11/18/27 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) Helen Hemmeter M. D.

8/29, 19 30 (Address) 1000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem Cemetery - Catonsville Md.

DATE OF BURIAL Aug. 30 1930

20 UNDERTAKER Charles J. Schwab.

ADDRESS 505 N. Monroe St

Spec.—1-30—M. & T.—250 Bks

E 60143 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60143

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. 15-62

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3803 Calloway Ave St. 15 WARD)

2-FULL NAME George W. Stevens.

(a) RESIDENCE NO. 3803 Calloway Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Stevens

6 DATE OF BIRTH (month, day, and year): Mar. 4, 1862

7 AGE — Years: 68 — Months: 5 — Days: 25 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Transportation 086

(b) General nature of industry, business, or establishment in which employed (or employer): Dept. Gas & Elec Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Del

PARENTS

10 NAME OF FATHER: Daniel D. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Del.

12 MAIDEN NAME OF MOTHER: Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del.

14 Informant: Mrs. Ella Stevens

(Address): 3803 Calloway Ave

15 Filed ..., 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1930, to Aug 28, 1930, that I last saw h[illegible] alive on Aug 28, 1930, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Apnphxy.

(duration) 3 hrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Lampesin, M. D.

, 19 (Address) 3405 Calloway Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown Md

DATE OF BURIAL: Aug 30, 1930

20 UNDERTAKER: Wm Pickrell Sons

ADDRESS: North x Pa

Spec.—2-29-28—L. F. S.—500 Bks.

E 60144

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60144

CERTIFICATE OF DEATH

124

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1956 Annapolis Ave ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Alice Kersey

(a) RESIDENCE NO. 1956 Annapolis Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Kersey

6 DATE OF BIRTH (month, day, and year): March 8, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: Fountain Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Susan Whiteley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Pearl Kersey

(Address): 1956 Annapolis Ave

15 Filed ——— 19 ——— Registrar

C. HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-29-30

17 I HEREBY CERTIFY, That I attended deceased from 8-27, 1930, to 8-29, 1930, that I last saw her alive on 8-29, 1930, and that death occurred, on the date stated above, at 4.10 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardio Vascular Renal Disease (duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph T. Lankards, M. D.

19 (Address) 1227 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisonburg Va	Sept 1 30
20 UNDERTAKER: Edward Lowe	ADDRESS: Wash Blvd

30 1930

Spec.—1-10-21—M&T—1500 Bks.

E 60145

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60145

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital ST., 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby White

(a) RESIDENCE NO. 1525 N. Patterson Park Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE: Years — Months — Days —

If LESS than 1 day, hrs. or 15 min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Thomas F. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md.

12 MAIDEN NAME OF MOTHER Regina M. Hoffmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Thomas F. White

(Address) 1525 Patterson Park Ave

15 Filed 8 30 1930, 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29 1930

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Aug 27, 1930,

that I last saw her alive on Aug 27, 1930,

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Victor Goldberg, M. D.

8/29, 1930 (Address) 1524 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Aug. 30 1930

20 UNDERTAKER: C. J. Fanning & Son — ADDRESS: Lafayette & Wash.

1-30—M. & T.—100 B—50L

E 60146

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60146

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1805 Thomas St. (15-64 WARD)

2-FULL NAME Albert D. Dorney

(a) RESIDENCE NO. 1805 Thomas St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma

6 DATE OF BIRTH (month, day, and year): Mar 10-1845

7 AGE: Years 85 | Months 5 | Days 19 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Grocer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Washington Dorney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Dore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Emma Dorney

(Address): 1806 Thomas St

15 Filed: 0 1930 Reg.: C. HAMPSON JONES, M. D.

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Luke Coroner, M. D.

Aug 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemy

DATE OF BURIAL: Sept 1 1930

20 UNDERTAKER: John O. Mitchell & Son

ADDRESS: 19 Eastern Ave

Cor.—12-5-25—A Co.—200 Bks.

E 60147

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60147

94-001

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital Ward) 418

2-FULL NAME Joseph M. Lounge

(a) RESIDENCE NO. 1310 Holbrook St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Mrs Annie B. Lounge

6 DATE OF BIRTH (month, day, and year) Sept 21, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Augusta Ga.

(State or country)

PARENTS

10 NAME OF FATHER Joseph Lounge

11 BIRTHPLACE OF FATHER (city or town)

(State or country) France

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Annie B. Lounge

(Address) 1310 Holbrook St.

C. HAMPSON JONES, M. D.

Registrar

AUG 30 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

Aug 29, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Harford Rd Date of Burial Sept 1, 1930

20 UNDERTAKER Elmer W. Conklin ADDRESS 924 E Eager

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60148 90 E 60148

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 Hilton ST. 20-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME R Wm. Arnold

(a) RESIDENCE NO. 324 Hilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret E. Arnold

6 DATE OF BIRTH (month, day, and year): Dec 6/54

7 AGE: Years 75 | Months 8 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Richard Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary A. Borchardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs Margaret E. Arnold

(Address) 324 Hilton st

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar.

3 01930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 29-30

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to Aug 29, 1930, that I last saw h[illegible] alive on Aug 28, 1930 and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John H Evans, M. D.

Aug 30 1930 (Address) 612 W 40

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Sept. 1 1930

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60149 E 60149

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST. 30-38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Hoffman

(a) RESIDENCE NO. 1936 Hollins St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Fred. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Ullrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital records.

(Address)

15 C. HAMPSON JONES, M. D. Registrar

D 1930 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29-30

17 I HEREBY CERTIFY, That I attended deceased from 8-11-30, 19..., to 8-29, 1930, that I last saw him alive on 8-29, 1930 and that death occurred, on the date stated above, at 6.07 p.m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis

of Abd viscera

Primary Carcinoma of peritoneum

(duration) 4 yrs.? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 8-12-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert S. Clements, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Sept 1 1930

20 UNDERTAKER J. Vernon Kehner

ADDRESS 153 Hollins

Spec.—1-30—M. & T.—250 Bks.

240203 60150 E 60150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Campbell

(a) RESIDENCE NO. Ramseur, N. C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER William Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mattie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant JOHNS HOPKINS HOSPITAL

(Address) Casual

15 Filed 8-30-1930, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30/30

17 I HEREBY CERTIFY, That I attended deceased from August 28, 1930, to August 30, 1930, that I last saw him alive on August 30, 1930, and that death occurred, on the date stated above, at 7039 m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Hydrocephalus

Ruice Birch (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-29-30

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Fred W. Gill M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro N C

DATE OF BURIAL 8/30/30

20 UNDERTAKER Jarvis Bros

ADDRESS 221 Bway

Spec.—1-30—M. & T.—250 Bks.

E 60151 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. (ST.) 10-14 (WARD) 16

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Todd

(a) RESIDENCE NO. 1029 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	—

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 28th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Tilghman Todd

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Hattie Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant G. Douglas

(Address) Johns Hopkins Hospital.

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-28-, 1930, to 7-6-, 1930, that I last saw h.e.r. alive on 7-6-, 1930, and that death occurred, on the date stated above, at 8 00 P. m.

The CAUSE OF DEATH* was as follows:

Premature Baby

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) G. Douglas M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL AUG 30 1930

20 UNDERTAKER Osborne Undertaking Co.

ADDRESS

0 1930 HAMPSON JOHNS, M. D. Registrar

Spec.—1-30—M. & T.—250 Bks.

E 60152 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60152

CERTIFICATE OF DEATH.

REGISTERED NO. 61

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST., 17-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cooper

(a) RESIDENCE NO. 1306 Argyle Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug. 1st 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Gertrude Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): H. G. Douglas Johns Hopkins Hospital.

15 Filed ... C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 2nd 1930.

17 I HEREBY CERTIFY, That I attended deceased from 8-1-1930, to 8-2-1930, that I last saw him alive on 8-2-1930, and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. G. Douglas M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: AUG 30 1930, 19

20 UNDERTAKER: Commissioner Health

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

Leiding

60153

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 4-25 47

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie B. Leiding

(a) RESIDENCE NO. 641 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. H. Leiding

6 DATE OF BIRTH (month, day, and year) Oct 1875?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework ?

(b) General nature of industry, business, or establishment in which employed (or employer) ? 0

(c) Name of employer ?

9 BIRTHPLACE (city or town) Montgomery Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Jacob Keister ?

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Lentenanzer ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

14 Informant Friends ?
(Address) Baltimore City Hosp.

15 Filed ..... 19 ..... Registrar .....

G 91 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-30-30

17 I HEREBY CERTIFY, That I attended deceased from 7-20-, 1930, to 8-30-, 1930, that I last saw h[illegible] alive on 8-30-, 1930, and that death occurred, on the date stated above, at 10 1/2 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach with metastasis to lungs.

(duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Fred M. Dreshwalds, M. D.

, 19 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Blacksburg Va.

DATE OF BURIAL 8/31/30

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60154 — 131 — E 60154

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH East Court apts.

CITY OF BALTIMORE: (No. Preston & St. Paul ST. 11-14 WARD)

2-FULL NAME Kate Caldwell Goldsborough

(a) RESIDENCE NO. East Court Apts. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced (or) WIFE of HUSBAND of: Judge Henry Goldsborough

6 DATE OF BIRTH (month, day, and year) Nov. 28th 1844

7 AGE: Years 85 | Months 9 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Mass.

PARENTS

10 NAME OF FATHER: John Caldwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass.

12 MAIDEN NAME OF MOTHER: Lucy Lord

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass. (Dayton)

14 Informant: Margaret Goldsborough
(Address) East Court

15 Filed 3 1 1930 BAKER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to Aug 30th, 1930, that I last saw her alive on Aug. 30th, 1930, noon, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Pyelo Cystitis (4 months)
Acute Toxaemia (3 days)

(duration) ..... yrs. 4 mos. 3 ds.

CONTRIBUTORY (Secondary) Senescence & Arteriosclerosis (duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urine Examination

(Signed) L. Dawson Leeds, M. D.

(Address) 30 E. Preston St. Aug 30, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Sept 1st 1930

20 UNDERTAKER: Henry Meinkemann & Son Co

ADDRESS: Oakland Ave & Colvin

Spec.—1-30—M. & T.—250 Bks

60155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60155

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 4-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Bollman

(a) RESIDENCE NO. 715 W. Lombard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-3-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment which employed (or employed) Matthews Paper Bx Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Timmerman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Records of Baltimore City Hosp.

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-28-30

17 I HEREBY CERTIFY, That I attended deceased from 8-9-30, 19..., to 8-28, 19 30.

that I last saw h... alive on 8-28-, 19 30,

and that death occurred, on the date stated above, at 10.15 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) unknown. yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

8-30, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery

DATE OF BURIAL 9/1/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60156 | 161-001 | E 60156

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3732 Buhler av St. 7-16 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy May Clifton

(a) RESIDENCE. No. 3732 Buhler av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-24-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 3732 Buhler av Balto md.

PARENTS

10 NAME OF FATHER Lloyd N Clifton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Evelyn Fritz 8-30

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co md

14 Informant Lloyd Clifton (Address) 3732 Buhler Ave

15 Filed ..., 19... Registrar

G 31 1930 C. HOWARD JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1930 to Aug 30, 1930.

that I last saw her alive on Aug 30, 1930.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH was as follows:

Prematurely born
about 5 mo. foetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) James S Ashurst M. D.

1930 Address 4012 Park Heights ave

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bals Cemetery

DATE OF BURIAL: 9/1 1930

ADDRESS

20 UNDERTAKER: J. Wm Cook 2075 Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60157

CERTIFICATE OF DEATH

11 VE 60157

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (St.) 22-43 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Caroline Christopher

(a) RESIDENCE NO. 6008 Harford Rd. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced (or) WIFE of John Milton Christopher

6 DATE OF BIRTH (month, day, and year) Sept 30, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER André Korb.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie - (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed AUG 31 1936 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 27, 1930, to August 30, 1930 that I last saw her alive on August 30, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Appendicitis
Peritonitis.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of August 29, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Robert V. Cheramie M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	9/2 1930
20 UNDERTAKER Wilhom Cook	ADDRESS 1217 E Pratt St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60158

CERTIFICATE OF DEATH.

45 ✓

E 60158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave ST. (8-12) WARD)

2-FULL NAME Mrs Mary Hucht

(a) RESIDENCE NO. 2102 E Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry

6 DATE OF BIRTH (month, day, and year): Apl. 17. 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joseph Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bavaria

12 MAIDEN NAME OF MOTHER: Anna Schweiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bavaria

14 Informant: Harry Hucht (Address) 2102 E Biddle St

Filed 3 1 1930, 19 J. MARK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-29 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-7, 1930, to 8-29, 1930, that I last saw her alive on 8-29, 1930, and that death occurred, on the date stated above, at 12:25 a m. Standard

The CAUSE OF DEATH* was as follows:

Carcinoma - ascending colon

Metastasis to liver

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary): (Ascites)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of attempt colotomy 7-18 30

Was there an autopsy? yes no

What test confirmed diagnosis? Frozen Section

(Signed) Hjalmer S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: 9/2/ 1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul st

Cor.—10-10-20—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8UE 60159

E 60159

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 177 S. Regester St. 2-4 Ward)

2-FULL NAME Mary Ratynski

(a) RESIDENCE NO. 177 S Regester St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Raymond Ratynski

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Raymond Ratynski
(Address) 1178 Regester

15 Filed JUL 31 1930 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute myocarditis
about 3 days
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No Of what? .....

What test confirmed diagnosis? Clinical

(Signed) James M Rawlings, M. D.

7/28, 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus DATE OF BURIAL: Sept 1 1930

UNDERTAKER: J N Bozewski ADDRESS: 930 Eastern Av

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60160

90 E 60160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. Gen Hosp. ST. 15-56 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Davis

(a) RESIDENCE NO. 352 Park Heights Ave ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced (or) WIFE of Rachael Davis

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Shoemaker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Lewis 1439 E Balto St.

15 Filed 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1930, to Aug. 24, 1930, that I last saw him alive on Aug 24, 1930 and that death occurred, on the date stated above, at 4.15 p m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerotic Cardio-Vascular Disease

& Hypertension

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 352 Park Heights Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lehman, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Russdals — DATE OF BURIAL 8-31- 1930

20 UNDERTAKER Jacob Lewis, 1439 E Balto St — ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 60161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Linden Ave., ST. 14-20 WARD)

2-FULL NAME Edi Fistel

(a) RESIDENCE NO. 2002 Linden Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Gittel Fistel

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Fistel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bertha —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1439 E. Baltimore St.

15 Filed 5-31-1930 19 M. H. Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29-30

17 I HEREBY CERTIFY, That I attended deceased from April 1930 to Aug 29th 1930.

that I last saw h~~im~~ alive on Aug 29th 1930.

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Steinberg M. D.

, 19 (Address) 3735 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levine Rosedale

DATE OF BURIAL 8-31-1930

20 UNDERTAKER Jos. Levine, 1439

ADDRESS E Balto St

Cor.—10-10-29—A Co.—100 Bks.

E. 60162

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60162

CERTIFICATE OF DEATH

REGISTERED NO. 188 x 93

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp. St. 26-37 Ward)

2-FULL NAME Milton L Eckman

(a) RESIDENCE NO. Mace Av Essex St., Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 hrs yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1924

6 DATE OF BIRTH (month, day and year) Nov 6-1924

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	9	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Chas H. Eckman

11 BIRTHPLACE OF FATHER (city or town) Harford Co
(State or country)

12 MAIDEN NAME OF MOTHER Mildred A Hesdrick

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Charles H Eckman
(Address) Mace Av. Essex

15 Filed AUG 31 1930 C. HAWKINS JONES M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by motor auto as he ran across road

(duration) yrs. mos. ds.

(A) Fract Skull

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mace Ave & Frances Rd

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Exam

(Signed) J. C. Faure, M. D.

8/31, 1930 (Address) 2939 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Lutheran Ch. Cem.

DATE OF BURIAL Aug 31 1930

UNDERTAKER John F. Connelly

ADDRESS Essex

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 60163

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60163

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Warren Ave ST. 22-33 WARD)

2-FULL NAME Marie E. Seiger

(a) RESIDENCE NO. 208 Warren Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Seiger

6 DATE OF BIRTH (month, day, and year) July 29. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Schafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Rutenorth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Seiger (Address) 208 Warren Ave

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Aug. 29, 1930, that I last saw her alive on Aug. 29, 1930, and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Apoplexy.

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Valvular heart (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ..... Dld an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

, 19 (Address) 125 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug 31, 1930.

20 UNDERTAKER c/o Mrs. John H. Tengle & Son

ADDRESS 801 W. Fayette

Sue C. 10-24-MAT—1500 Bks.

E 60164

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60164

CERTIFICATE OF DEATH.

+ 49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) W-50 (Ward)

2-FULL NAME William Joseph Meskill.

(a) RESIDENCE NO. 2905 N. Charles St., Ward Mass.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aline Meskill.

6 DATE OF BIRTH (month, day, and year) June 17, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	38 yrs.	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norwood, Mass.

PARENTS

10 NAME OF FATHER Wm. Meskill.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Doran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant J. M. Hart (Address) 411 Roland Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30/1930

17 I HEREBY CERTIFY, That I attended deceased from 3/17, 1930, to 8/30, 1930, that I last saw him alive on Aug. 30, 1930, and that death occurred, on the date stated above, at 9:10 P. m. E.S.T.

The CAUSE OF DEATH* was as follows:

Carcinoma of Antrum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 2-13-30

Was there an autopsy? No. 3-27-30

What test confirmed diagnosis? Path. Report 4-24-30. 5-6-30 5-13-30

(Signed) Robert A. Bruce, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md.

DATE OF BURIAL 8/31 1930

20 UNDERTAKER Wilhoyte

ADDRESS 1219 Eutaw

G 3 1 1930

Cor.—12-9-25—A Co.—200 Bks.

Cazzone

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60165

CERTIFICATE OF DEATH.

187-606

E 60165

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel ~~Samuel~~ Cazzone

(a) RESIDENCE NO. 320 East St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frances Guzzone

6 DATE OF BIRTH (month, day, and year) IV-24-1884

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	45	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Samuel Guzzone
11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Frank Guzzone
(Address) 320 East 1st

15 Filed 3-1 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28-30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Intestine
1 day about
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Peritonitis
(duration) ... yrs. ... mos. ... ds.

(Signed) H. T. Finley M. D.
(Coroner)

Aug 30, 1930 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial 9/1/30

20 UNDERTAKER George D Roth Inc ADDRESS 1535 Harford

very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60166 — 84 E 60166

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 E. University Parkway St. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME W. Leo Haigley

(a) RESIDENCE NO. 201 E. University Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 18th. 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Haigley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto,

12 MAIDEN NAME OF MOTHER Susan Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Miss Margaret Haigley.

(Address) 201 E. University Parkway.

15 Filed 3 1 1930 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30th. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to Aug 30, 1930, that I last saw him alive on Aug 30, 1929, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis c pericarditis
followed by cerebral embolism
c right sided hemiplegia

(duration) yrs. 2 mos 10 ds.

CONTRIBUTORY (Secondary) Angina pectoris (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Cardiograph

(Signed) Herman G Voigt, M. D.

, 19 (Address) 3106 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL 9/2 1930

ADDRESS

20 UNDERTAKER Chas R Traut & Son 1184 Mt Royal Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60167

E 60167

CERTIFICATE OF DEATH.

REGISTERED NO. 15-65 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3709 Nortonia Road ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. McCormick

(a) RESIDENCE NO. 3709 Nortonia Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 11th, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bermuda Islands

PARENTS

10 NAME OF FATHER Michael McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen McCormick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Katherine L. Healy

(Address) 3709 Nortonia Road

15 Filed 3-1 1930. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 8 - 30, to Aug - 28, 1930.

that I last saw her alive on Aug - 28, 1930.

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma, terminus in left Parotid Gland, becoming general in region, face and neck (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage from Nose & Throat (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

8/29, 1930 (Address) 2202 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL Sept 1st 30.

20 UNDERTAKER Chas. F. Evans & Son

ADDRESS 1180 Mont Royal Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60168 — 129 — E 60168

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 60168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4527 Pimlico Road ST., 27 WARD 56

2-FULL NAME John Witham Mc-Donald

(a) RESIDENCE NO. 4527 Pimlico Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Mc Donald

6 DATE OF BIRTH (month, day, and year) Sept. 25 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Dist of Columbia

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Mary Sparrow

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Mrs Donald
(Address) 4527 Pimlico Road

15 Filed 3 1 1930 19 C. H. JACKSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 29 19 to Aug 29 19 30.

that I last saw him alive on Aug 29 19 30. at 7.30 m.

and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

Contributory (Secondary) (duration) yrs. mos. ds.

Contributory (Secondary) Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. H. Stout M. D.

, 19 (Address) 4527 Pimlico Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview — DATE OF BURIAL Sept 1 1930

ADDRESS

UNDERTAKER

ADDRESS Joseph Sypher & Co Monument

Spec.—8-16-29—L. F. S.—100 Blks.

E 60169 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60169

129

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH U.S. Marine Hospital

CITY OF BALTIMORE: (No. Baltimore, Md. ST. 26-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph H. Hall

(a) RESIDENCE NO. 432 N. Bouldin St., Baltimore, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 1, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer Baltimore Steam Packet Co.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Richard B. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Hannah B. Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records, U.S. Marine Hospital Baltimore, Md.

(Address)

15 Filed AUG 31 1930 CHARLES JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to August 30, 1930, that I last saw him alive on August 30, 1930 and that death occurred, on the date stated above, at 8:15 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic several years (duration) yrs. mos. ds.

CONTRIBUTORY Nephritis, chr., interstitial unknown

Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & lab. findings

(Signed) Gordon A. Abbott, M. D.

8/30, 1930 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Sept. 2 1930

20 UNDERTAKER Joseph H. Cook

ADDRESS 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Blks

E 60170 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60170

CERTIFICATE OF DEATH.

REGISTERED NO. 96

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) ST., 11-24 WARD)

2-FULL NAME Holden Sims.

(a) RESIDENCE NO. 619 Jasper ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob Sims.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Laura Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md.

14 Informant Records Dr. (Address) BALTIMORE CITY HOSPITALS

15 Filed 3 T 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1930, to Aug 29, 1930, that I last saw him alive on Aug. 29, 1930, and that death occurred, on the date stated above, at 6:50 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and hypertension (duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically am.

(Signed) Paul Padget, M. D.

8-29 1930 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 8-30 1930

20 UNDERTAKER Ernest O'Kennedy ADDRESS 578 W. Baltimore

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60171

CERTIFICATE OF DEATH

E 60171

REGISTERED NO. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 538 N. Preston St. (WARD) 12-24

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Washington

(a) RESIDENCE NO 538 N. Preston St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	44	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Washington (Address) 538 N. Preston St

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28th 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. Sudden

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. C. Fluke M. D.
Coroner

(Address) Aug 29th 19 30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Aug 31 19 30

UNDERTAKER Samuel Hemsley ADDRESS 1526

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60172

90 E 60172

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) In front 1020 W. Lafayette St. (or) WARD 20

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Johnson

(a) RESIDENCE NO. 340 W. Lafayette St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND (or) WIFE of: Philip Johnson

6 DATE OF BIRTH (month, day, and year): Jan 25-1870

7 AGE — Years: 60 | Months: 4 | Days: 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Carrie E. Moody

(Address): 1328 Druid Hill

15 Filed AUG 2 1930 HARRY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Jones, M. D. Coroner

July 29 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Sept 30

20 UNDERTAKER: Edward Hensley ADDRESS: 1778 Bridge

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60173

CERTIFICATE OF DEATH.

162

E 60173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1929 Penna Ave. ST. 14-20 WARD)

2-FULL NAME Infant Son of John A. & Blanche Jones

(a) RESIDENCE NO. 1929 Penna Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	—

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 29 1930

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	—	—	1	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John A. Jones

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Blanche Jones

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant John A. Jones
(Address) 1929 Penna ave

Filed G 3 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30. 30

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1930, to Aug 30, 1930.

that I last saw h— alive on Aug 30, 1930,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis with Primary Asphyxia of New Born

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Harry F. Brown, M. D.

8/30 1930 (Address) 1916 Penna ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Aug 31 30
20 UNDERTAKER Samuel Beasley	ADDRESS 1728 McCulloh

Spec—12-23-21—E.B.R.S.—400 Bks.

E 60174

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 60174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE; (No. 15 W Clarkson 23-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Betty Jane Vogelgesang

(a) Residence No.... 15 W Clarkson ..... St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, (White or Black) White

5-Single, Married, Widowed, or Divorced (Write word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 29 1930

7-AGE. — yrs. 1 mos. — ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... none

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER George Vogelgesang

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Lottie Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14-

(Informant) George Vogelgesang

(Address) 15 W Clarkson St

15-Filed ..... 1930 MARSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29 1930

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1930 to Aug 29 1930 that I last saw her alive on Aug 29 1930 and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. L. Campbell M. D.

8/29 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery DATE OF BURIAL, Sept 1 1930

20-UNDERTAKER. Morgan G. Flynn ADDRESS 14 W Eighth St.

1-30—M. & T.—10C B—50L

E 60175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 60175

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enroute St. Joseph Hospital 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Riordan

(a) RESIDENCE No 1300 Wilcox ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23/1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) State Sanatorium
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Timothy Riordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Whalen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Timothy Riordan Brother

(Address) 1300 Wilcox St

Filed SEP 1 1930 [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 17 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) [signature] Coroner, M. D.

8/31/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL Sept-1 1930

ADDRESS

20 UNDERTAKER Rita Riedefeld 914 Fremont Ave

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60176

E 60176

CERTIFICATE OF DEATH.

15-68

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1728 Durkeland St. WARD)

2-FULL NAME Katherine C. McGee

(a) RESIDENCE NO. 1728 Durkeland (Cumberland Md) WARD Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Peter McGee

6 DATE OF BIRTH (month, day, and year) September 24-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Eckhart Md

PARENTS

10 NAME OF FATHER ? McGee Hoop

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs George Hardwood

(Address) 1728 Durkeland St

15 1930 C. HARROW JONES, M. D. Registrar

Filed ....., 19.....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1930, to Aug 31, 1930, that I last saw her alive on Aug 31, 1930, and that death occurred, on the date stated above, at 2.45 P m. D.S.T.

The CAUSE OF DEATH* was as follows:

Arteria-sclerosis

(duration) 2 yrs. mos da.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. 3 mos da.

18 Where was disease contracted if not at place of death? Cumberland Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Leech, M. D.

Aug 31, 1930 (Address) Temple Garden Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md

DATE OF BURIAL Aug 31 1930

20 UNDERTAKER W. J. Tuckwiller & Sons

ADDRESS Cumberland

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60177

58-001 ✓

CERTIFICATE OF DEATH

E 60177

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 N Elwood Ave ST. 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Henry Costello

(a) RESIDENCE NO. 303 N Elwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) March 2nd 1927

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
3		5	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Walter E. Costello

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Penna.

12 MAIDEN NAME OF MOTHER Anna Marie McInerney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Walter E. Costello

(Address) 303 N Elwood Ave

Filed 1st 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29-30

17

I HEREBY CERTIFY, That I attended deceased from Sept 16 1930 to Aug 29, 1930, that I last saw h[illegible] alive on Aug 25, 1930 and that death occurred, on the date stated above, at 9.45 P m. EST

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Refused

What test confirmed diagnosis? Examination of blood

(Signed) Edward Leon (Physician) M. D.

Aug 31 1930 (Address) 416 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catherdal Cem	Sept 1st 1930
20 UNDERTAKER	ADDRESS
Leo G. Cook	1723 Patt Pk Ave

Cor.—10-10-29—A Co.—100 Bks.

E 60178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 60178

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. University Hospital St., 18-29 Ward)

2-FULL NAME Benjamin B. L. Parker

(a) RESIDENCE NO. 1009 Boyd St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Letta Parker

6 DATE OF BIRTH (month, day, and year) July 22-1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	1	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Canfield Ship'g Co

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Myrtle Heasley
(Address) 1009 Boyd St

15 Filed 8-1-1930 19 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Talbert, M. D.

8/2, 1930 (Address) 2109 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 9/3/1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

Important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

60179

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+159-002 ✓

E 60179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hopkins Hospital ST. 7-4 WARD)

2-FULL NAME Betty Shenton

(a) RESIDENCE NO. Turner's Station ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co., Md

PARENTS

10 NAME OF FATHER Thos. Shenton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Agnes Goralski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Hospital Records

(Address)

15 Filed 1930 C. HARRY JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inqu ry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Heart-Dehydration
Necrosed Peyer's (Parches) Glands.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature], M. D. Coroner

8-30-30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL Sept 1 1930

20 UNDERTAKER George W. Zirkler

ADDRESS 737 E Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60130 — 47 — E 60130

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 S. Lakewood Ave ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Froehlich

(a) RESIDENCE NO. 616 S. Lakewood Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Henry Froehlich

6 DATE OF BIRTH (month, day, and year): May 25, 1869

7 AGE — Years: 61 — Months: 3 — Days: 5 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John S. Hagelgans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry H. Froehlich

(Address) 616 S. Lakewood ave

15 Filed 1-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct —, 1917, to Aug 30, 1930, that I last saw h alive on Aug 29, 1930, and that death occurred, on the date stated above, at 12.20 A. m.

The CAUSE OF DEATH* was as follows:

Uremia - chronic nephritis

Carcinoma of breast & mediastinum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/14

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8/31/1930 (Address) 1014 S. Lakewood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: Sept 1. 1930

UNDERTAKER: H. Sander Sons Inc.

ADDRESS: 1710 Eutaw St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60131 — 118-02 — E 60131

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry B. Schmeltz Jr. Catonsville Md.

(a) RESIDENCE NO. 110 Dalton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary E. Schmeltz

6 DATE OF BIRTH (month, day, and year) Jan 17 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66		7	12	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Retired.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry B. Schmeltz

11 BIRTHPLACE OF FATHER (City or town) (State or country) Bernard Germany

12 MAIDEN NAME OF MOTHER Barbara Schwartz

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Hospital Records.

(Address)

15 Filed SEP 1 - 1930 C. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 1930. to Aug 29 1930.

that I last saw him alive on Aug 29 1930.

and that death occurred, on the date stated above, at 3.10 P m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Gall Bladder

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of 8/21/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) G. Bowie Kenyon M. D.

8/29, 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 2nd 1930

20 UNDERTAKER J. S. Sheppard

ADDRESS 850 W. Balto St

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

60182 ✓ T 113 E 60182

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hopkins Hospital ST. 7-9 WARD)

2-FULL NAME Frances Hook

(a) RESIDENCE NO Wise Ave & north Point Rd. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16/1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	1	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nuture of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Samuel Hook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Catherine Martriki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Samuel Hook
(Address) Wise ave & North Pt. Road

15 Filed SEP 1 - 1930 G. HAMILTON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nutritional Dis turbance
(Unidentified)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Carter, M. D. Coroner

8/31/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harmed Beach of Mary Sept 1 19 30

DATE OF BURIAL

20 UNDERTAKER John M Weber W. A. Chester

ADDRESS

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001 ✓

E 60183

CERTIFICATE OF DEATH.

E 60183

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 10-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Eich

(a) RESIDENCE NO. 6002 Eastern ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Eich

6 DATE OF BIRTH (month, day, and year): Jan 28-1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Keeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country):

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country):

14 Informant (Address): Mrs. Eich 6002 Eastern ave

15 Filed 1-6 1930, 19[illegible] [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Uraemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Dec 31 1930 (Signed) [illegible] M. D. (Coroner)

(Address) 539 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemt. Date of Burial: Sept 3 1930

20 UNDERTAKER: Lilly & Zeiler Inc ADDRESS: 403 So Wolfe St.

very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

237490 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5V E 60184

E 60184

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irving Hornickesburg

(a) RESIDENCE NO. 125-N. Ausquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Heyman Hornickesburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Asher Schuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant JOHNS HOPKINS HOSPITAL Branch

(Address) H. HAMMOND JOHNS, M. D.

Filed 9-1-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31-30

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1930 to Aug 31, 1930, that I last saw him alive on Aug 31, 1930, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Rheumatic heart disease.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Rheumatic Fever

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Campbell Goodwin M. D.

8/31, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 9-1-1930

20 UNDERTAKER Jacob Lewis, 1439

ADDRESS E. Balto St.

Spec.—1-30—M. & T.—250 Bks

E 60185 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60185

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 S. Hare ST., 12 WARD)

2-FULL NAME Mary E. Buczkowski —

(a) RESIDENCE NO. 37 S. Hare ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Joseph Buczkowski

6 DATE OF BIRTH (month, day, and year) Oct. 25th 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	37	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William H. E. Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Catherine Easgrove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Joseph Buczkowski (Husband) (Address) 37 S. Hare St

Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29/30

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to Aug 29, 1930, that I last saw h e alive on Aug 29, 1930, and that death occurred, on the date stated above, at 10.40 a. m. E.S.T.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Hx. of (8 months)

(duration) yrs. 8 mos da.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. 10 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) L. P. Rostling, M. D.

(Address) 1827 W. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem.

DATE OF BURIAL Sept 2 1930

20 UNDERTAKER Lillye Zeiler Inc

ADDRESS 403 N. Wolfe St

FEB 1 1930 HAMPSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60186 E 60186 X 188-203

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St. 26-37 Ward)

2-FULL NAME Peter Jones

(a) RESIDENCE NO. 608 Sar Sparrows Pt. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 - 1908

7 AGE	Years	Months	Days	IF LESS than 1 day .... hrs. or .... min.
	21	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Presley Jones

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Spotwood

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Harvey Jones
(Address) Sparrows Pt. Md.

15 Filed SEP 1 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Stated he was struck collided with truck Crushed R Leg

(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Gas Bacillus Inf.

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? Edgemere Rd

Did an operation precede death? yes Date of 8-29-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. J. Frame, M. D.

9-1, 1930 (Address) 7939 Mr. Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sparrows Pt

DATE OF BURIAL 9-1 1930

20 UNDERTAKER Wm. H. Lease

ADDRESS 1400 Mosher

important. See instructions on back of certificate.

E 60137

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60137

CERTIFICATE OF DEATH

31

REGISTERED NO. 24-35

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph J. Winterling

(a) RESIDENCE NO 1120 Haubert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frances Winterling

6 DATE OF BIRTH (month, day, and year) Dec 24/1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	8	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo. Winterling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Catherine Moser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Mrs. Frances Winterling
(Address) 1120 Haubert ST

15 Filed 9-1-1930 [illegible] JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pneumothorax- Rt Side

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably Tuberculosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D. Coroner

9/1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A A Co

DATE OF BURIAL 9/4 1930

UNDERTAKER [illegible] Williams Cook

ADDRESS 1217 St Paul

Spec.—8-16-29—L. F. S.—100 Bks.

Wm Cook 1217 St. Paul St.

E 60188

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002 E 60188

CERTIFICATE OF DEATH

REGISTERED NO. 77-35

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 East Hill ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Asa E Ingram

(a) RESIDENCE NO. 29 E Hill St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie D Ingram

6 DATE OF BIRTH (month, day, and year): May 31 1880

7 AGE: Years 50 | Months 3 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Hamilton

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Henry Ingram

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Helen Robinson

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Cal

14 Informant: Nellie Ingram

(Address): 29 E Hill St

15 Filed ..., 19... [illegible] Registrar

1 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31, 1930

17

I HEREBY CERTIFY, That I attended deceased from Aug 30, 1930, to Aug 31, 1930,

that I last saw h alive on Aug 31, 1930

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Acute dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. B. Campbell, M. D.

Aug 31, 1930 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg Va

DATE OF BURIAL: 9/3 1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 E Pratt St

Use typewriter or pen and ink. Do not write in this space. See instructions on the back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60139 ✓ E 60139

E 60139

CERTIFICATE OF DEATH

REGISTERED NO. + 102

1—PLACE OF DEATH Maryland Gen. Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Madison-Linden ST. 11-24 WARD)

2—FULL NAME Mr. Homer Wilt

(a) RESIDENCE NO. Parkersburg, W. Va. ST., WARD Parkersburg W. Va. (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Homer Wilt

6 DATE OF BIRTH (month, day, and year) July 24, 1892

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
38	1	11 da	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Parkersburg W. Va.

10 NAME OF FATHER Mr Fred Wilt

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Black

13 BIRTHPLACE OF MOTHER (city or town)? (State or country)

14 Informant Hospital records

(Address)

Filed SEP 1 - 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 23 1930, to Sept. 1, 1930, that I last saw him alive on Sept. 1, 1930, and that death occurred, on the date stated above, at 2 00 A.m. Stand. T.

The CAUSE OF DEATH* was as follows:

Bronchiectasis (duration) 10? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy with effusion? (duration) yrs. mos. 21 ds.?

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug. 31, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Robert T. Chevrault, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Md

DATE OF BURIAL 9/1- 1930

20 UNDERTAKER William Cook

ADDRESS 1217 Sylvan

Spec.—1-30—M. & T.—250 Blks

E 60190 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 60190

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospital ST. 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME James Smith

(a) RESIDENCE NO. Pennsylvania Ave. & Collet ST., (Res Unknown) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Smith

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greensboro North Carolina

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Louisa Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address) Hospital Record

15 Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26/30

17 I HEREBY CERTIFY, That I attended deceased from 8/25/30, 19 .... to 8/26/30, 19 ....

that I last saw h.. alive on 8/26/30, 19 ....

and that death occurred, on the date stated above, at 9 Am m.

The CAUSE OF DEATH* was as follows:

Caseous Pneumonia

(duration) .... yrs. .... mos unknown da.

CONTRIBUTORY (Secondary) (duration) .... yrs. .... mos. .... da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) David Steiner M. D.

8/26/30 (Address) Baltimore City Hosp. Path

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 9-1 1930

ADDRESS 711 Gay

UNDERTAKER David Taylor

Spec.—8-16-29—L. F. S.—100 Bks.

E 60191 ✓ E 60191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N Durham ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ramon Peta

(a) RESIDENCE NO. 808 N Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ramon Peta

6 DATE OF BIRTH (month, day, and year): not known

7 AGE — Years: 56 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cuba

PARENTS

10 NAME OF FATHER: Victor Peta

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cuba

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cuba

14 Informant: Ramon Peta

(Address): 808 N Durham St

15 Filed 1-1930, 19 [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 29/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Aug 29, 1930, that I last saw h alive on Aug 27, 1930, and that death occurred, on the date stated above, at 8:50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Rogers M. D.

Aug 30, 1930 (Address) 801 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 2 1930

20 UNDERTAKER: Frank Brach Son — ADDRESS: 1906 Gilmor

Spec.—1-30—M. & T.—250 Bks.

238251
E 60192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60192

REGISTERED NO. 60-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 713 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Thomas

(a) RESIDENCE NO. 803 Shuter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	married

6a If married, widowed, or divorced (HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Emanuel McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Stella McNeill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed 1-1930, 19 H. Beck JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29-30

17 I HEREBY CERTIFY, That I attended deceased from 6-22-, 1930, to 8-29, 1930, that I last saw h er alive on 8-29, 1930, and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows: Exophthalmic Goitre

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Post operative shock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Aug 29, 1930

Was there an autopsy? yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Rawley M. Pemick Jr, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount N. C.	Sept 1, 1930
UNDERTAKER Mack & A. Elliott	ADDRESS 1726 Madison Ave

Spec.—8-16-29—L. F. S.—100 Bks. E 60193 E 60193

E 60193 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60193

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH U.S. Marine Hospital, Baltimore Md. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 9-46 ST., WARD)

2—FULL NAME Thomas C Weedon

(a) RESIDENCE NO. 2027 E 31 ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Weedon

6 DATE OF BIRTH (month, day, and year) 3/13/1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot

(b) General nature of industry, business, or establishment in which employed (or employer) Marine

(c) Name of employer B C & A R.R.

9 BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Thomas W Weedon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Stephens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant U.S. Marine Hospital records

(Address)

15 Filed 2-1930, 19 CHAMPION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 30

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 29, 19, to Aug 31, 1930, 19, that I last saw h[illegible] alive on Aug 31, 1930, 19, and that death occurred, on the date stated above, at 8 20 m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Nephritis Chronic
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension
Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) J H Jones, M. D.

, 19 (Address) U.S. Marine Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Quaker Burying Ground West River Md

DATE OF BURIAL 9/3/1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Bks

E 60194 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60194

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 35 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Schaeffer

(a) RESIDENCE NO. 16 S. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown 2/6/1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Fort

(c) Name of employer Balto Md

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick Shaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Patty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Records of Balto. City Hosp.

15 Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-30

17 I HEREBY CERTIFY, That I attended deceased from 8-27-30, 19..., to 9-1-30, 19...,

that I last saw him alive on 9-1-30 19...,

and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Alcoholism, chronic and acute; Alcoholic Psychosis; Korsakow's Syndrome (duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. Exam. Autopsy

(Signed) Paul Padget, M. D.

9-1, 19 3 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 9/3/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60195

CERTIFICATE OF DEATH

185 4

E 60195

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) ST. AGNESS HOSPITAL St. 14-20 Ward)

2-FULL NAME Brigie Ann Doyle

(a) RESIDENCE NO. 1412 Linden Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
White	FEMALE	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of SINGLE

6 DATE OF BIRTH (month, day, and year) Jany.6.1854

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
76	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Not any
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Doyle

11 BIRTHPLACE OF FATHER (city or town) IRELAND
(State or country)

12 MAIDEN NAME OF MOTHER Mary Doyle

13 BIRTHPLACE OF MOTHER (city or town) IRELAND
(State or country)

14 Informant Catherine Skelton
(Address) 1412 Linden AVE.

15 Filed AUG 2 - 1930 19.. C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUGUST 30. 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency Fell down steps & Some fracture of left arm & injuries (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward H. Mook, M. D.

Aug 31 1930 (Address) 3601 Hanover St. Bmd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cemetery Long Green, Balto. Co. DATE OF BURIAL Sept. 2, 1930

20 UNDERTAKER John O. Mitchell & Sons, 1900 Eutaw P. ADDRESS

John O. Mitchell

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60196 V-002 E 60196

CERTIFICATE OF DEATH.

13-52 12 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4023 Falls Road. ST., 13-52 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Bishop.

(a) RESIDENCE NO. 4023 Falls Road. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin A. Bishop.

6 DATE OF BIRTH (month, day, and year) July 9, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. John T. Bishop.
(Address) 4023 Falls Road.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 31, 1930, that I last saw h[illegible] alive on Aug 31, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

CONTRIBUTORY (Secondary) Chronic Cystitis (duration) yrs. 2 mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) C. F. Campbell M.D.

9-1-30, 19 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Sept 3 1930

20 UNDERTAKER Chas. W. Chase

ADDRESS 3615 Chestnut Ave.

9-2-1930 W. HAMBY JONES Registrar

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60197 E 60197

CERTIFICATE OF DEATH.

129

REGISTERED NO. 13-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3143 Keswick Road. ST. WARD)

2-FULL NAME Mary A. Litsinger.

(a) RESIDENCE NO. # 3143 Keswick Road. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 22, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trained Nurse.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James M. Litsinger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Barnes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. John Lutz.
(Address) # 3143 Keswick Road.

15 Filed P 2 - 1930 16 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 28 th, 1930, to Aug 31 st, 1930, that I last saw h[er] alive on Aug 30, 1930, and that death occurred, on the date stated above, at 1[15] a. m.

The CAUSE OF DEATH* was as follows:

Cardiovascular Renal disease

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Right Hemiplegia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) C. W. Dieudonne, M. D.

Sept 1, 1930 (Address) 830 W 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Sept 2, 1930

20 UNDERTAKER Chisom Olson

ADDRESS 3615 Chestnut Ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60198

REGISTERED NO. 90 E 60198

1-PLACE OF DEATH

City of BALTIMORE: (No. 612 N. Streeper St. St. 7-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Alder.

(a) RESIDENCE NO. 612 N. Streeper St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced Clara Grimes

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Alder. Dec 27/1881

6 DATE OF BIRTH (month, day, and year): Jan ? 1882.

7 AGE: Years 48 Months 8 Days 2

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment to which employed (or employer): Penna. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: William Alder.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Phoebe Pitts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Mr. Franklin H. Seitz.

(Address): 1505 Carswell St.

Filed SEP 2 - 1930

H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) J. S. H. Cullen, M. D. (Coroner)

8/31/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: G. Mayn Hampson

Date of Burial: Sept 3 1930

20 UNDERTAKER: Thos. W. Hilton

ADDRESS: 3615 Gwynns Falls Ave.

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60199 46 E 60199

CERTIFICATE OF DEATH

REGISTERED NO. 12-50

1—PLACE OF DEATH Maryland General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Broadway & Howard ST., (WARD)

2—FULL NAME Sarah A. McCready

(a) RESIDENCE NO. 2842 St. Paul ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. 5 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 20 1898

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	5	10	

OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER Joseph L. McCready

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York State

14 Informant Joseph L. McCready
(Address) 2842 St Paul St

Filed 2-1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 30, 1930, that I last saw h[er] alive on Aug 29, 1930 and that death occurred, on the date stated above, at 5:10 a m.

The CAUSE OF DEATH* was as follows:

Sarcoma of uterus with metastasis to pelvis & abdomen

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 8/16/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Robert K. Cleveland, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Sept 2 1930

UNDERTAKER W. M. Routson

ADDRESS 2238 N Booth

Spec.—1-30—M. & T.—250 Bks.

E 60200

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60200

CERTIFICATE OF DEATH.

REGISTERED NO. 1446

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1305 N Broen ST. 21-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia M Kral

(a) RESIDENCE NO. 1305 N Broen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J Kral

6 DATE OF BIRTH (month, day, and year) Oct 2 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER James Tuck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rosa Fultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Andrew J Kral

(Address) 1305 N Broen at

15 FILED SEP 2 - 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31/30

17 I HEREBY CERTIFY, That I attended deceased from 8/31, 1930, to 8/31, 1930, that I last saw h alive on 8/31, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Post Partum Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Placenta Previa

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 8/31/30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edmond J. Tracy, M. D.

8/31/1930 (Address) 9 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Sept 3 1930

20 UNDERTAKER W M Routson

ADDRESS 2038 N Mth

Spec.—1-30—M. & T.—250 Bks

E 60201

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60201

CERTIFICATE OF DEATH.

90

REGISTERED NO. 28-64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4804 Gwynn Oak Ave ST. ..... WARD)

2-FULL NAME Christian Frederick Zehnder

(a) RESIDENCE NO. 4804 Gwynn Oak Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary H Zehnder

6 DATE OF BIRTH (month, day, and year) Nov 12 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfr Agt Printing Inks

(b) General nature of industry, business, or establishment in which employed (or employer) 345

(c) Name of employer

9 BIRTHPLACE (city or town) Phila Pa
(State or country)

PARENTS

10 NAME OF FATHER David Zehnder

11 BIRTHPLACE OF FATHER (city or town) Sunbury Pa
(State or country)

12 MAIDEN NAME OF MOTHER Emma Kuemmerle

13 BIRTHPLACE OF MOTHER (city or town) Phila Pa.
(State or country)

14 Informant Mary H Zehnder
(Address) 4804 Gwynn Oak Ave

15 Filed 2 1930 19 H. A. KELLY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 30

17 I HEREBY CERTIFY, That I attended deceased from June 1 1930 to Aug 30 1930
that I last saw h[illegible] alive on Aug 30 1930
and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus Viridens blood stream infection about 3 mos ds.
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chronic mayocarditis about 1 yrs. ..... mos. ..... ds.
(duration)

18 Where was disease contracted
If not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Lab. examinations

(Signed) Walter Dubbert M. D.

Aug 30 1930 (Address) 2220 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hillside Cem. Phila Pa.

DATE OF BURIAL Sept 3 1930

20 UNDERTAKER Harry H Amaco Aston 4204 Ridgewood Ave

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60202 (149) E 60202

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Floyd

(a) RESIDENCE NO. 564 Gough St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Baby

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Floyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Combs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Johns Hopkins Hospital (Address)

15 Filed 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29/30

17

I HEREBY CERTIFY, That I attended deceased from August 26, 1930, to August 29, 1930, that I last saw her alive on August 29, 1930, and that death occurred, on the date stated above, at 4.35 p m.

The CAUSE OF DEATH* was as follows:

Summer Diarrhea

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Campbell Goodman M. D.

8/29 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Aug 29 1930

UNDERTAKER Lewis Easter

ADDRESS 516 N Gay

Spec.—1-30—M. & T.—250 Bks.

239936

E 60203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

E 60203

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. JOHNS HOPKINS HOSPITAL ST. L-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory W. Wooley

(a) RESIDENCE NO. 431 N. Linwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of anna Wooley

6 DATE OF BIRTH (month, day, and year) July 7 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER A. W. Wooley

11 BIRTHPLACE OF FATHER (city or town) (State or country) mich

12 MAIDEN NAME OF MOTHER Matilda Chapman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) mich

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed 1930 C. MAHON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930 to Aug 31, 1930, that I last saw h alive on Aug 31, 1931, and that death occurred, on the date stated above, at 150 A m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Arteriosclerosis - coronary

Myocardial (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) 4 mo.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. Townley Paton M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Sept 3 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 60204

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60204

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1366 Washington Blvd 21-29 WARD)

2-FULL NAME Jesse A. Downey

(a) RESIDENCE. No 1366 Washington Blvd, ST., 21 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary E. Downey

6 DATE OF BIRTH (month, day, and year) Feb. 22d 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

030

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George O. Downey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Andrew J. Winkler
(Address) 1366 Washington Blvd.

15 Filed ..... 19 ..... H. [illegible] JONES, M. D. Registrar

2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1930, to Aug 31, 1930, that I last saw h in alive on Aug 31, 1930, and that death occurred, on the date stated above, at 6:50 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. H. Triplett, M. D.

19 (Address) 1324 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel, Md.	Sept 2nd 1930

20 UNDERTAKER Jacob Winkler Sons ADDRESS Manchester Md

Spec.—8-16-29—L. F. S.—100 Bks.

E 60205 HEALTH DEPARTMENT—CITY OF BALTIMORE 62 E 60205

E 60205 Gov Sheppard General Hospital

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1512 Gilmor ST. 7-24 WARD)

2—FULL NAME Infant of Evangeline Johnson

(a) RESIDENCE NO. 1313 Myrtle Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 28 1930

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: Chas. Johnson Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Viola Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Chas. Johnson

(Address) 1313 Myrtle Ave

15 Filed SEP 2 - 1930 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31 / 30

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Aug 31, 1930, that I last saw h[illegible] alive on Aug 31, 1930 and that death occurred, on the date stated above, at 10:35 AM

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Congenital

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 1512 Gilmor

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M Zion Ku, M. D.

, 19 (Address) 1512 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem. DATE OF BURIAL: Sept 2nd 1930

20 UNDERTAKER: Frank Hemsley ADDRESS: 1711 Bolton

Spec.—1-30—M. & T.—250 Bks.

E 60206 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60206

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE, (a) No. 748 Wasche ST. 18-Ha (WARD)

2-FULL NAME Ella Tinney

(a) RESIDENCE NO. 748 Wasche ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE: Years 56 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ella Jones
(Address) 748 Wasche St.

Filed Sept 2 1930 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17th 1930 to Aug. 30th 1930, that I last saw her alive on Aug 30 30 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

History (duration) about 3 mos ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) Jas E Bell M. D.
, 19 (Address) 713 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Sept 2 1930

UNDERTAKER Simmons Hemsley & Biddle ADDRESS 378

Spec.—1-30—M. & T.—250 Bks.

E 60207 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 60207.

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH President Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division St. 11-24 WARD)

2-FULL NAME John Johnson

(a) RESIDENCE NO. 505 Cathedral ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of ind business, or establishment i which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Katie Scott (Address) 1505 Cathedral St

15 [illegible] THOMPSON JONES, M. D. Registrar

SEP 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug: 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1930, to Aug: 29, 1930, that I last saw him alive on Aug: 29, 1930, and that death occurred, on the date stated above, at 1.09 p.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Valvular Heart Disease not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Carroll M McClain, M. D.

, 19 (Address) President Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Sept. 2 1930

20 UNDERTAKER Wm G. G Socks

ADDRESS 1502 Jefferson

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60208 — REGISTERED NO. E 60208

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 328 S Oldham St ST. 26-37 WARD

2-FULL NAME George Adey

(a) RESIDENCE NO. 328 S Oldham ST ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Lottie J Adey

6 DATE OF BIRTH (month, day, and year) Dec 19-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Machenic

(b) General nature of industry, business, or establishment in which employed (or employer) Brewery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Lottie J Adey Wife

(Address) 328 S Oldham ST

15 Filed P 2 - 1930 By HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-30-30

17 I HEREBY CERTIFY, That I attended deceased from July 1 30 to Aug 30 30

that I last saw h[illegible] alive on Aug 30 30

and that death occurred, on the date stated above, at 20 p. m.

The CAUSE OF DEATH was as follows: Mitral Regurgitation (Rheumatic)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Sept 2 1930

UNDERTAKER Ltlly & Zeiler Inc 403 S

ADDRESS Wolfe St

Rev—12-23-21—E.B.R.S.—400 Eas.

E 60209 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 60209

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 S. Dean St., 26 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Knapp

(a) Residence No. 711 S Dean St., 26 Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Femal

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~ Widowed, ~~or Divorced~~ (~~Write the word~~)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Maritz Knapp

6-DATE OF BIRTH (month, day and year): Jan 20-1859

7-AGE: 71 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS

10-NAME OF FATHER: unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Anna Schnabel (Address) 711 S. Dean st.

15- Filed ..... 192 ..... Registrar

7-1930 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 31-1930

17- I HEREBY CERTIFY, That I attended deceased from 11/ 29 19.. to 8/30 1930

that I last saw her alive on 8/30 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Carnell M. D.

8/31 1930 (Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem DATE OF BURIAL: Sept 3 1930

20-UNDERTAKER: Lilly & Zeiler INC ADDRESS 1033 W. Fayette

Spec.—1-30—M. & T.—250 Blks.

E 60210

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60210

CERTIFICATE OF DEATH.

101-00

REGISTERED NO. 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 505 E. 28th. ST. (WARD)

2-FULL NAME Annie C. Hudson

(a) RESIDENCE NO. 505 E. 28th. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of William Hudson

6 DATE OF BIRTH (month, day, and year) Dec. 15-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) York Co.

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James Perigo

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania

(State or country)

12 MAIDEN NAME OF MOTHER Grove

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania

(State or country)

14 Informant Talbert M. Hudson

(Address) 505 E. 28th. St.

15 Filed Aug 3 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31-1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 29 1930 to Aug 31 1930

that I last saw her alive on Aug 31 1930

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Sudden

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Old Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Hudson M. D.

Aug 31 1930 (Address) 1112 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norrisville Cem. Harford Co.

DATE OF BURIAL Aug 3 1930.

20 UNDERTAKER Horace M. Burgee

ADDRESS 2031 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60211

CERTIFICATE OF DEATH. 152 E 60211

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave ST. 76-10 WARD)

2-FULL NAME Charles Leatherman

(a) RESIDENCE NO. 3600 McTavish Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Bessie

6 DATE OF BIRTH (month, day, and year) Feb 16 1877

7 AGE: Years 53; Months 6; Days 15; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Josiah

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Bessie Leatherman 3600 McTavish Ave

15 Filed SEP 2 - 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31 — 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-21 , 1930 , to 8-31 , 1930 .

that I last saw him alive on 8-31 — , 1930 .

and that death occurred, on the date stated above, at 6 30 a m. Standard

The CAUSE OF DEATH* was as follows:

Hemorrhage -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infection of hand & arm (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Incision & Drainage 8-23-30

Did an operation precede death? Yes - Date of 8-29-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert Dieruf , M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 9/3 30

20 UNDERTAKER: Fayette Furley Fulton

ADDRESS: Fayette

Spec.—1-30—M. & T.—250 Bks

E 60212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60212

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2216 Corbin road ST. 27-43 WARD

2-FULL NAME Albert Wigner

(a) RESIDENCE NO. 2216 Corbin road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or Wife of~~ Anna D. Wigner

6 DATE OF BIRTH (month, day, and year) Oct 20/93

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) State Road

(c) Name of employer Com.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Wigner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lottie Kolbe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna D. Wigner

(Address) 2216 Corbin road

15 Filed 2-1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30/30

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Aug 30, 1930,

that I last saw him alive on 8/30

and that death occurred, on the date stated above, at 8 03 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) X. W. Gokey M. D.

, 19 (Address) 5703 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL 9/2 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60213

CERTIFICATE OF DEATH

32 ✓

E 60213

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Preeco

(a) RESIDENCE NO. 744 No. Schroeder ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 13 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	13	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Preeco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Gates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Marie Preeco

(Address) 744 No. Schroeder St

15 Filed SEP 2 1930 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1930, to Aug. 30, 1930, that I last saw h.r alive on Aug. 30, 1930 and that death occurred, on the date stated above, at 12:35 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningetis

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 744 No. Schroeder St

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) L. Peter Menaneke, M. D.

8/30, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lion Cemetery	Sept 2, 1930
20 UNDERTAKER	ADDRESS
Mrs Kate R. Williams	3207 Schroeder St

Spec.—1-10-21—M&T—1500 Blks.

Gannon

E 60214 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60214

CERTIFICATE OF DEATH.

REGISTERED NO. 44759

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2522 Pennsylvania Ave WARD)

2-FULL NAME William Joseph Gannon

(a) RESIDENCE NO. 2422 Pennsylvania Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): June 15-1875

7 AGE: Years 55; Months 2; Days 16; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer St Joseph Coledge

9 BIRTHPLACE (city or town) (State or country): Irish

PARENTS

10 NAME OF FATHER: Wm J. Gannon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Claghin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Wm E. Gannon

(Address) 222 S Woodyear St

15 Filed 9-2-1930, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1930, to Aug 31, 1930, that I last saw him alive on Aug 30, 1930, and that death occurred, on the date stated above, at 6.30 A-m.

The CAUSE OF DEATH* was as follows:

Cardiac Dropsy

CONTRIBUTORY (Secondary) Cancer of Liver (duration) yrs. 8 mos. ds.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. F. Hawkins, M. D.

(Address) 6 Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: 9-3-1930

20 UNDERTAKER: H. S. Fink — ADDRESS: 2612 Walbrook

HAMPSON JONES, M.D.

IMPORTANT—See instructions on back of certificate

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60215

CERTIFICATE OF DEATH

E 60215
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hos St. 15-56 Ward)

2-FULL NAME Simon Mitowsky

(a) RESIDENCE NO. 2811 Norfolk Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Mitowsky

6 DATE OF BIRTH (month, day, and year) Dec Nov 1871

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or ... min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 80
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Theresa Mitowsky
(Address) 2811 Norfolk Ave

15 Died 9-2 1930 12 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
While Crossing Street was struck & knocked down by moving auto

Duration 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Ribs Multiple Left side - Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Reisterstown Rd 6500 Block

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) L. Hamm M. D.

9/2 1930 (Address) 2934 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	Sept 2 1930
20 UNDERTAKER	ADDRESS
S. Levinson Bros.	E. Bd. Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 60216

E 60216

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore General Hospital REGISTERED NO. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 425 ST. W. Fayette MARD)

2-FULL NAME Mrs. Sarah Jane Cunningham

(a) RESIDENCE NO. 11 W Franklin ST., _____ WARD _____ (If non-resident give city or town and State)

(Usual place of abode) How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

Length of residence in city or town where death occurred 20 yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Late Nathan N Cunningham

6 DATE OF BIRTH (month, day, and year) Feb 1, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Ross Eaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Krout

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Kent C. Hammond (Address) 11 W. Franklin St.

15 Filed SEP 2 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 - 1930

17 I HEREBY CERTIFY, That I attended deceased from August 29, 1930, to August 31, 1930.

That I last saw her alive on August 31, 1930, and that death occurred, on the date stated above, at 6 40 Am.

The CAUSE OF DEATH was as follows:

Chronic hypertensive cardio-vascular renal disease

(duration) 8 yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Acute cerebral hemorrhage (duration) _____ yrs. _____ mos. 2 ds.

18 Where did disease contracted if not at place of death? at home

Did an operation precede death? No Date of _____

Was there an autopsy? No What test confirmed diagnosis? Clinical tests

(Signed) Wm Jr. Sullivan M. D.

, 19 (Address) So. Balti Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Md

DATE OF BURIAL 9/3 1930

UNDERTAKER Harry V. Witzke ADDRESS 4101 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

E 60217 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60217

CERTIFICATE OF DEATH.

REGISTERED NO. 25-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3504 Eaton av ST., 20-7 WARD)

2-FULL NAME Charles H. Kettler

(a) RESIDENCE NO. 3504 Eaton av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Nellie A. Kettler

6 DATE OF BIRTH (month, day, and year): April 10 1887

7 AGE: Years 43 | Months 4 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Painter

(b) General nature of industry, business, or establishment in which employed (or employer): 650

(c) Name of employer: Kettler Bros

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Henry Kettler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helen Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Nellie A. Kettler

(Address) 3504 Eaton av

19 2 - 1930 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30/30

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Aug 30, 1930, that I last saw h alive on aug 29 1930, and that death occurred, on the date stated above, at 5 ..... m.

The CAUSE OF DEATH* was as follows:

Cessation of vital bodily functions due to heart weakness, incurred by ~~accident~~ illness (Primary) 1 year yrs. mos. ds.

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. G. Jones, M. D.

9. 2. 1930 (Address) 26 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery DATE OF BURIAL: Sept 2 1930

UNDERTAKER: J. A. Hufnagel ADDRESS: 1850 W Balto St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 E 60218

E 60218

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 421 W White Ave ST., (WARD) 27-42

2-FULL NAME Henry Warner

(a) RESIDENCE NO. 421 W White Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Mary E. Warner

6 DATE OF BIRTH (month, day, and year): Oct 10 1860

7 AGE — Years: 69 — Months: 10 — Days: 20 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

PARENTS

10 NAME OF FATHER: Isaac Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Emily Johnson
(Address) 421 W White Ave.

15 Filed 2-1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10/30 to Aug 30 19 30.
that I last saw h alive on Aug 30 19 30
and that death occurred, on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows: Cancer left lung —
Hemmorhage
(duration) ... yrs. ... mos ... ds.
CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Symptoms

(Signed) W D Coffee M. D.
19 (Address) 2121 Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Sept 2 1930

20 UNDERTAKER: Fred H Lassahn Sons — ADDRESS 740 Belair Rd

HAMPSON JONES, M.

Spec.—1-30—M. & T.—250 Bks.

E 60219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60219

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baptist Home

CITY OF BALTIMORE: (No.) 1615 Park Ave. ST. 14-20 (WARD)

2-FULL NAME Minnie F. Hoffman

(a) RESIDENCE NO. 1615 Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Kate Hush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records of Baptist Home

(Address) 1615 Park Ave.

15 Filed 2-1930 19 CLAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31/30

17 I HEREBY CERTIFY, That I attended deceased from 8/6/30, 19..., to 8/29, 1930, that I last saw her alive on 8/29/30, 19..., and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular

(duration) 5 yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) coma

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Gen Exa

(Signed) G V S Lor, M. D.

9/1, 1930 (Address) 836 W. North a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Sept. 2, 1930

20 UNDERTAKER John O. Mitchell & Sons,

ADDRESS 1900 Eutaw Pl

Cor.—10-10-29—A Co.—100 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60220 * 101-001 E 60220

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) Balto City Hosp. St., 15-6 Ward)

2-FULL NAME Thomas Galloway

(a) RESIDENCE NO. 244 Aiken St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	24	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Hedric Galloway

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Carrie Capers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant Wm Galloway
(Address) 244 Aiken St

15 Filed SEP 2 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Double Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 244 Aiken St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

8/31/1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedony Cemetery — DATE OF BURIAL Sept 2 1930

20 UNDERTAKER Mac. R. G. Elliott — ADDRESS 1725 Argyle

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 60221

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60221

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 5105 Whitelock ave WARD 48)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Eliz. Bacon
(a) RESIDENCE NO. 5105 Whitelock ave WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE W. | 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jno E. Bacon

6 DATE OF BIRTH (month, day, and year) July 11 1869

7 AGE Years 81 | Months 1 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or estab lishment in which employed (or employer)
(c) Name of employer

PARENTS
9 BIRTHPLACE (city or town) (State or country) Md
10 NAME OF FATHER Josiah Shellard
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.
12 MAIDEN NAME OF MOTHER Frances Coffroe
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eng

14 Informant Mrs. Shellard (Address) 5105 Whitelock ave

15 Filed 2-1930 19 HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1-1930

17 I HEREBY CERTIFY, That I attended deceased from June 5 1927 to Sept 1 1930.
that I last saw h alive on Aug 31 1930
and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis, Ch. Nephritis
Ch. Myocarditis

(duration) 2+ yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What tests confirmed diagnosis? Gross findings
(Signed) E. W. Bishop, M. D.
(Address) 521 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL 9/3/1930
UNDERTAKER J. A. Moran ADDRESS 300 E Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60222

CERTIFICATE OF DEATH

105

E 60222

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2715 Fait ave ST. 1-3 WARD)

2—FULL NAME Albert Strugala

(a) RESIDENCE NO. 2715 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: widower

6 DATE OF BIRTH (month, day, and year): April 23 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: American Smelting & Ref. Co.

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Casimir Strugala

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Julia Strugala

(Address) 2715 Fait Ave.

15 Filed 9-2 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-1-30

17 I HEREBY CERTIFY, That I attended deceased from 3-10-30, 19..., to 9-1-30, 19...,

that I last saw him alive on 9-1-30, 19...

and that death occurred, on the date stated above, at 11:0 a m.

The CAUSE OF DEATH* was as follows:

Chronic Asthmatic Bronchitis

(durntion) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. B. Bronushas, M. D.

9-2-30 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: N. Strausdans Cem

DATE OF BURIAL: Sept 2 1930

20 UNDERTAKER: Stephen J. Fialkowski

ADDRESS 1000 S Kenwood ave

Spec.—8-16-29—L. F. S.—100 Blks.

E 60223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 31

REGISTERED NO. E 60223

1—PLACE OF DEATH U. S. Marine Hospital,

CITY OF BALTIMORE: (No. Baltimore, Maryland, ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andres Martinez

(a) RESIDENCE NO. 313 Water St., ST. New York, New York. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 19 How long in U. S., if foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2,1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Seaman

(c) Name of employer SS Mistley Hall(British)

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER Ramo Martinez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Mary Marino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant U.S.Marine Hospital Records

(Address) Baltimore, Maryland.

15 Filed P 2 - 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 12, 1930, to September 1, 1930, that I last saw him alive on September 1, 1930, and that death occurred, on the date stated above, at 12:20 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, active.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumothorax, spontaneous, left, due to pulmonary tuberculosis.

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory findings

(Signed) Gordon A. Abbott M. D.

9/2, 1930 (Address) U.S.Marine Hospital, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem

20 UNDERTAKER 1020 Dr H B Cook

DATE OF BURIAL Sept 3" 1930

ADDRESS 1023 N Paca St

Spec.—1-30—M. & T.—250 Bks

E 60224

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60224

CERTIFICATE OF DEATH.

REGISTERED NO. 69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 837 Franklin (ST.) (18-7½ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Johnson

(a) RESIDENCE NO. 837 Franklin ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	black	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Mildred Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mildred Johnson

(Address) Baltimore Md

Filed SEP 2 1930, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/23/30, 1930, to 8/25, 1930, that I last saw her alive on Aug 25, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease of the new born

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History and Clinical Exam

(Signed) [illegible], M. D.

8/28, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19 SEP 2 - 1930

20 UNDERTAKER [illegible] Health.

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60225

E 60225

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Jenkins Memorial Hospital 1000 Caton Ave ST., 9-13 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine C. Carroll

(a) RESIDENCE NO. 707 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs — mos — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced, (write the word) Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25 1864

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
65	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10 NAME OF FATHER James Collins
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Catherine Carol.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jenkins Memorial Hospital 1000 Caton Avenue.

15 Filed 9-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-22 1930 to 8/31 1930
that I last saw h.. alive on 8/31 1930
and that death occurred, on the date stated above, at 2.00 P. m. E.S.T.
The CAUSE OF DEATH* was as follows:
Carcinoma of rectum

(duration) 1 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of May 1929
Was there an autopsy? No
What test confirmed diagnosis? Pathological findings at operation

(Signed) Robert Oliver M. D.
(Address) St. Agnes Hospital.
, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery
DATE OF BURIAL Sept. 3 1930
20 UNDERTAKER Chas. F. Evans & Son ADDRESS 1180 N. Royal Ave.

Spec.—1-30—M. & T.—250 Bks

E 60226 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60226

CERTIFICATE OF DEATH.

REGISTERED NO. 124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 906 St. Paul ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Rothwell Stewart

(a) RESIDENCE NO. 906 St. Paul ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-15-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vocal Instructor

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm. H. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Port Penn Dela.

12 MAIDEN NAME OF MOTHER Sarah E. Murphey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md

14 Informant Miss Stewart - Sister
(Address) 906 St. Paul St.

15 [illegible] 19 [illegible] HAMPSON JONES, M. D. Registrar

2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 14th, 1930, to Sept 1st, 1930, that I last saw her alive on Sept 1st, 1930, and that death occurred, on the date stated above, at 6 05 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chron. Cholecystitis (myocard failure) myocard. failure (duration) 2 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 5/9/30

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frances H. Fillis, M. D.

, 19 (Address) 20 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown, Md.

DATE OF BURIAL 9/4 1930

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

Spec.—1-30—M. & T.—250 Bks.

E 60227 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60227

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St. 25-77 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Dwelle

(a) RESIDENCE NO. 6300 Arundel Cove Apt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of George Dwelle

6 DATE OF BIRTH (month, day, and year) Mar. 22, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	18 yrs	4 mo.	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Bertha Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant JOHNS HOPKINS HOSPITAL

(Address)

File 2-1930 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/30

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Sept 1, 1930, that I last saw h.e alive on Sept 1, 1930, and that death occurred, on the date stated above, at ..m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension Arteriosclerosis

Uremia

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) (Chronic) ? Pyelonephritis. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Benj. M. Baker M. D.

Sept 1, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL 9/3/30 19

20 UNDERTAKER J. Ahrens & Co ADDRESS 2432 R Road

Spec.—1-30—M. & T.—250 Bks.

E 60228 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 60228

100

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division ST. 8-16 WARD)

2-FULL NAME Milton Summerville

(a) RESIDENCE NO. 1353 N. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Colored	infant

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Summerville

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mary Summerville
(Address) 1353 N. Fremont Ave

15 Filed 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to Sept. 1, 1930,

that I last saw him alive on Sept. 1, 1930,

and that death occurred, on the date stated above, at 5.55 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 2½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL E-2 1930

ADDRESS 916 Pine

20 UNDERTAKER Daniel Easton

1-30—M. & T.—100 B—50L

E 60229

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60229

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 957 Druid Hill St. 11-24 (WARD)

2-FULL NAME John R. Wilson

(a) RESIDENCE NO 957 Druid Hill St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Wilson

6 DATE OF BIRTH (month, day, and year) Aug 15-1891

7 AGE Years 39 Months — Days 16 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Parkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Christina Wilson
(Address) 957 Druid Hill

15 C. HAMPSON JONES, M. D. Registrar
1930 Aug

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 31st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. Sudden

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Leitch Coroner, M. D.

(Address) Corner N. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedarville Md

DATE OF BURIAL 9-3 1930

20 UNDERTAKER David Easton

ADDRESS 976 Pa ave

Spec.—1-30—M. & T.—250 Bks.

E 60230

E 60230 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. 15-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017 Clifton Avenue ST. WARD)

2-FULL NAME Elizabeth Heiman Sirich

(a) RESIDENCE NO. 3017 Clifton Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of J. Henry Sirich

6 DATE OF BIRTH (month, day, and year) November 5/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Joel Heiman

11 BIRTHPLACE OF FATHER (city or town) ? ?

(State or country) Conn.

12 MAIDEN NAME OF MOTHER Jeremena Dunn

13 BIRTHPLACE OF MOTHER (city or town) ? ?

(State or country) O Fus

14 Informant Mrs. C. B. Mann (son-in-law)

(Address) 3017 Clifton Avenue

15 Filed SEP 2 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930, to Aug. 31 st, 1930, that I last saw her alive on Aug. 31 st, 1930, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - (angina pectoris) acute pulmonary Edema.

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 15 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) S. A. Dodder, M. D.

Sept 2, 1930 (Address) 317 Medical Arts Bl. Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 3/30

ADDRESS

UNDERTAKER Stewart & Mowen Co. 108 W. North Avenue

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60231

CERTIFICATE OF DEATH

E 60231

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mun. Hosp. S. 4-30 Ward)

2-FULL NAME Vivian Berry

(a) RESIDENCE NO. Annapolis Rd Rosemont Md Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 1-1923

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	7			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Annapolis

PARENTS

10 NAME OF FATHER Ira Berry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ida Ford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ira Berry
(Address) Rosemont Md

15 9-2 1930 THOMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & Knocked down by moving auto while walking along road

2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Annapolis Rd Rosemont

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) T J Thum M. D.

9/2, 1930 (Address) 2939 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem. Baltimore Md	Sept 5 1930
20 UNDERTAKER D. L. Hopkins	ADDRESS Annapolis Md

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60232

E 60232

CERTIFICATE OF DEATH

REGISTERED NO. 199

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sous Balto Hos St. 24-33 Ward)

2-FULL NAME Chas Chapman

(a) RESIDENCE NO. Dont Know St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Dont Know
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 1930 19 HAMILTON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Taxi cab in which he was riding Collided with another car ordinary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Track Knee

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Barnet Manor

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Comm

(Signed) H. Irani M. D.

9/1 1930 (Address) 24 31st & Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side foc additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Mt Pleasant Apt 3	
20 UNDERTAKER John C. McClellan	ADDRESS 35 E Lexington

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60233

CERTIFICATE OF DEATH

182 E 60233

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Curtis Bay. St. 10-18 Ward)

2-FULL NAME Wilburn F. Siegman.

(a) RESIDENCE NO. 1307 Old Harford Road. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 1, 1907

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	23	2	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith helper.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Lehnhardt & S

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Benjamin F. Siegman.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mattie Auld.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore, Md.

14 Informant Benjamin F. Siegman. (Father)
(Address) 1307 Old Harford Road.

15 Filed ....., 19 HAMPSON JONES, M. D. Registrar
2 - 1930 AFA

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 1, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental drowning while in swimming.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Leuthardt, M. D.

9/2, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwarz

DATE OF BURIAL 9/5 1930

20 UNDERTAKER [illegible]

ADDRESS 1217 Eutaw

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

Dr Rusiska 200 N. Patterson Pk. 7-24-0127

E 60234 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60234

CERTIFICATE OF DEATH. 7 51

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 Broadway ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor S. Smith

(a) RESIDENCE NO. 4408 - 77th st N.Y. City. WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ or) WIFE of David L. Smith

6 DATE OF BIRTH (month, day, and year) 7/27/1877

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	53	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self Balto Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John W Harrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eleanora Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Chas. E. Harrigan

(Address) 2122 Antoinette St Detroit

Filed 2-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/30

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Sept 1, 1930.

that I last saw h alive on Sept 1, 1930

and that death occurred, on the date stated above, at 12 Nn.

The CAUSE OF DEATH* was as follows:

Endocarditis Chronic

Septic Staphylococcus

Viridans (13) mos ds.

(duration) yrs

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Ned Dugan M.D.

9-1, 19 30 (Address) 600 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 9/3 1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

E 60235

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60235

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 452 E. Fort Ave. ST. 24-33 WARD

2-FULL NAME Christina Moon.

(a) RESIDENCE NO. 452 E. Fort Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry C. Moon.

6 DATE OF BIRTH (month, day, and year) Feb 17, 1862.

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68.	6.	14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: William Schaener.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Margaret Unger.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Anna M. Moon. (Daughter)

(Address): 452 E. Fort Ave.

15 Filed 2-1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930, to Sept 1, 1930, that I last saw h.. alive on Sept 1, 1930, and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yr. mo. 14 d.

CONTRIBUTORY (Secondary) Chronic Nephritis & arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Sh. Wise, M. D.

, 19.. (Address) 4033 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: Sept 4, 1930

UNDERTAKER: A. Howard Evans

ADDRESS: 38 E Hoffman

8pec.—1-30—M. & T.—250 Blks.

E 39506 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60236

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Schnitzel

(a) RESIDENCE No. Lead S. Dakota ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	unknown

5a If married, widowed, or divorced HUSBAND of or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Sept-20-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mining Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria

PARENTS

10 NAME OF FATHER Phillip

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alsace

12 MAIDEN NAME OF MOTHER Lechrida Kaeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alsace

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed 9-3-1930 C. HAWES JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-2-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1930 to Sept 2, 1930.

that I last saw him alive on Sept 2, 1930

and that death occurred, on the date stated above, at 5-45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? South Dakota

Did an operation precede death? yes Date of 2 yrs ago

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) L. D. Smith M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lead South Dakota

DATE OF BURIAL Sept 3, 1930

20 UNDERTAKER John Merrick

ADDRESS 2108 Arlington

Spec.—1-30—M. & T.—250 Bks.

E 60237 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60237

CERTIFICATE OF DEATH. 57 REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 1920 N. Monroe ST. 15-21 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella M. Cawman

(a) RESIDENCE NO. 1920 N. Monroe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Samuel Cawman

6 DATE OF BIRTH (month, day, and year) March 16th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	5	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS
10 NAME OF FATHER Wm A Reed
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER ? Sudler
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Editha Mullendore
(Address) 1920 N. Monroe St

Filed SEP 3 - 1930 HARRY JONES, Registrar

MEDICAL CERTIFICATE OF DEATH 8.40 P.M.

16 DATE OF DEATH (month, day, and year) Sept 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to Sept 1 - 1930,
that I last saw her alive on Sept 1 - 1930, 8.40 P. m.
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(duration) yrs. 9 mos ds.
CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No What test confirmed diagnosis? Physical Signs
(Signed) Wm L Bryant M. D.
9/2, 1930 (Address) 1928 N Fulton Ave Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Hill Md
DATE OF BURIAL 9/3/1930
UNDERTAKER Wm Cook
ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

60238 E 60238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH Baltimore City Hosp (If death occurred in a hospital or institution, give its NAME instead of street and number.) ST. 11-24 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Essie Campbell

(a) RESIDENCE NO. 717 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Tennessee Va.

PARENTS

10 NAME OF FATHER Wm Campbell ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Anna Palmer

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Va.

14 Informant Friends ? (Address) Baltimore City Hospitals

15 Filed ....., 19 ..... Registrar R&K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-30

17 I HEREBY CERTIFY, That I attended deceased from 3-19, 1930, to 9-1, 1930, that I last saw h[illegible] alive on 9-1-1930, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam

(Signed) Fred M. Dunkum M. D.

, 19 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 3, 1930

20 UNDERTAKER Samuel D Beasley — ADDRESS 578 N Bridle

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60239 129 E 60239

CERTIFICATE OF DEATH

E 60239

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1936 Brunt ST. (WARD) 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Solomon Trippi

(a) RESIDENCE NO. 1936 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60+ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Trippe

6 DATE OF BIRTH (month, day, and year) May 10 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	2 3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chair Repairer

(b) General nature of industry, business, or establishment in which employed (or employer) St. Walter 070

(c) Name of employer Baltimore Bleach & Talbott Co. Inc

9 BIRTHPLACE (city or town) (State or country) Talbott Co Md

PARENTS

10 NAME OF FATHER James Trippi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co Md

12 MAIDEN NAME OF MOTHER Rebecca Maxfield

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbott Co Md

14 Informant Solmon Trippi

(Address) 1936 Brunt St

15 Filed 3-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31-1930

17 I HEREBY CERTIFY, That I attended deceased from November 3 1927 to Aug 31 1930, that I last saw h[illegible] alive on Aug 30 1930 and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia Cerebral (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. H. Wood, M. D.

(Address) 1209 Presstman 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Sept 3 1930

20 UNDERTAKER Frank P. Kennedy ADDRESS 578 N Eutaw

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60240 — E 60240

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 60240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 18-26 (WARD)

2-FULL NAME John Murdsen (Lloyd.)

(a) RESIDENCE NO. 800 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Samuel Smith

(Address) 2114 Druid Hill Ave

15 Filed ..... 192 ..... Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feltes, M. D. Coroner

9/3. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 9/3 1930

20 UNDERTAKER Chas C. Hampson Sons, Inc.

ADDRESS 1700 N. Eden

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 60241

CERTIFICATE OF DEATH

113

E 60241

REGISTERED NO. 1429

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 S Casey ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A. Stein

(a) RESIDENCE NO. 210 S. Casey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 24th 1929.

7 AGE: Years | Months 8. | Days 7 8. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Michael D. Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ethel Spearman

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr Michael D Stein

(Address) 210 S Casey St

15 Filed SEP 3 HAMPSON JONES, U. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1930.

17 I HEREBY CERTIFY, That I attended deceased from 9/1/30. 19..., to 9/1/30. 19..., that I last saw h[illegible] alive on 9/1/30. 19 30 and that death occurred, on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) Hrs by "friend who".

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Bernard J. Terry, M. D.

9/3 1930 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL 9/3/1930

ADDRESS

20 UNDERTAKER John J Howard Son

901 Holliday St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 60242 HEALTH DEPARTMENT—CITY OF BALTIMORE 109-002 E 60242

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2810 St. Paul ST. 12-50 WARD)

2—FULL NAME Cora Crise Evans

(a) RESIDENCE NO. 2810 St. Paul ST.. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clarence R. Evans

6 DATE OF BIRTH (month, day, and year): Nov. , 1876

7 AGE — Years: 53 | Months: 10 | Days: | If LESS than 1 day, ...hrs. or ....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home duties 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John L. Crise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Malinda Raborg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Herbert E. Rossman

(Address): 2810 St. Paul St.

15 Filed SEP 3 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 3, 1930, to Sept 2, 1930, that I last saw h.. alive on Sept. 2, 1930, and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

Vincents Angina

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Laboratory Examination

(Signed) Geo. M. Little, M. D.

9/2, 1930 Address) 1 x 130 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Sept. 4, 1930

UNDERTAKER: John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

M. B. Mitchell

Spec. 4-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60243 — REGISTERED NO. E 60243

1-PLACE OF DEATH 1053 W. Lemington St — ST. 16-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Victoria Moore

(a) RESIDENCE NO. 1053 W. Lemington ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Rynie Moore Eastman

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Not definitely known apparently over 60 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick, Md

PARENTS

10 NAME OF FATHER George Milburn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER Miss Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co. Md.

14 Informant (Address): Alice V. Dayton 2458 N 59th St Philadelphia Pa.

15 Filed 19 C. HAMPSON JONES, M. D., Registrar

3 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 . 1930, to Sept 1 . 1930

that I last saw h alive on Sept 1 . 1930.

and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage softening

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles T. Woolley M. D.

. 19 (Address) 1205 Myrtle Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn ct — DATE OF BURIAL: Sept 4 1930

20 UNDERTAKER: A. L. Brown & Son — ADDRESS: 108 W. Mosher St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-203

E 60244 — REGISTERED NO. E 60244

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Agnes Hospital St., 70-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gorman Myers

(a) RESIDENCE NO. 1938 W. Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. H. Myers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Etchison

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mr. A. Hart Etchison

(Address) Frederick Md.

15 Filed SEP 3 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 / 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Struck & knocked down by auto

(a)

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Fract Skull

(Duration) ...yrs. ...mos. ...ds.

(Signed) L. Faust M. D.

(Coroner)

19 (Address) 2939 McElderry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs.. ...mos.. ...ds. In the State ...yrs.. ...mos.. ...ds.

Where was disease contracted if not at place of death? Trash Road

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick, Md. Date of Burial Sept 3 1930

20 UNDERTAKER Sept 3 Cook ADDRESS 1003 West Baltimore St

very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

É 60245

E 60245 HEALTH DEPARTMENT—CITY OF BALTIMORE É 60245

CERTIFICATE OF DEATH. REGISTERED NO. 57

1-PLACE OF DEATH Provident Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division St. 15-21 WARD)

2-FULL NAME Clara Forrester

(a) RESIDENCE NO. 717 Gold St., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Richard Forrester

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 29

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Issac. Cullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Emeline Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Frederick A. Cullen

(Address) 717 Gold St. city

15 Filed SEP 3 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1930 to Aug 31, 1930, that I last saw h[illegible] alive on Aug 31, 1930, and that death occurred, on the date stated above, at 4.40 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) undetermined yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Connally Med Exam, M. D.

(Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Sept 3 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 303 Presstman St

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 NE 60246

CERTIFICATE OF DEATH

E 60246

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 Jefferson ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Kouba

(a) RESIDENCE NO. 2212 Jefferson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vincent Kouba

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 67 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Joseph Kouba

(Address): 2212 Jefferson

15 Filed ... 19 ...

S - 1930 G. H. SUDLOW SONS-BALTO.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 2/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Sept 1, 1930, that I last saw him alive on Sept 1, 1930, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows: Tuberculosis Pulmonary

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Wallace Long M. D.

3, 1930 (Address) 1800 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 5 1930

20 UNDERTAKER: Frank Leach — ADDRESS: 1906 Eastern

Spec.—1-30—M. & T.—250 Bks.

E 60247 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60247

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH Sinai Hospital ST. 15-56 WARD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.)

2-FULL NAME Leon Saltzman

(a) RESIDENCE NO. 2504 Pearlestone Pk. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5-1-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Pupil
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS
10 NAME OF FATHER William Saltzman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Pauline Kaven
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Baltimore St.

15 Filed 9-3-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Sept. 3, 1930, that I last saw him alive on Sept. 3, 1930, and that death occurred, on the date stated above, at 2:20 a.m.

The CAUSE OF DEATH* was as follows:
Ruptured appendix followed by calculus obstruction and generalized peritonitis 3 wks.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.
Did an operation precede death? yes. Date of Sept. 3, 1930
Was there an autopsy? no.
What test confirmed diagnosis? Physical Signs
(Signed) M. S. Cohen, M. D.
, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Friendship
DATE OF BURIAL 9-3-1930

20 UNDERTAKER Lewis Jos. Lewis, 1439 Balto
ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60248

E 60248

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 503 Oxford ST. 17th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Franklin Langley

(a) RESIDENCE NO. 503 Oxford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Langley

6 DATE OF BIRTH (month, day, and year) Jan 16, 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Bottler

(b) General nature of industry, business, or establishment in which employed (or employer) Soft Drink Mfg.

(c) Name of employer Doeman Ginger Ale Baltimore, Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Langley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Langley. (Address) 644 Mosher St.

15 Filed SEP 3 1930 19

16 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1930, to Aug. 31, 1930, that I last saw h[illegible] alive on Aug 30, 1930 and that death occurred, on the date stated above, at 10.30 a. m. E.S.T. me

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) One yrs mos ds.

Exhaustion

CONTRIBUTORY (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) W. Gallagher, M. D.

9/2, 1930 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Sept 3, 1930

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Madison Ave

THIS IS VERY IMPORTANT. See instructions on reverse side.

Spec.—1-30—M. & T.—250 Bks.

Viola Fearse

E 60249

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60249

CERTIFICATE OF DEATH.

1-001

REGISTERED NO.

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division St. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Fearse

(a) RESIDENCE NO. 21 N. Caston East ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Mary Fearse

(Address) 21 N. Caston St

15 Filed SEP 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 25, 1930, to Sept. 1, 1930, that I last saw h[illegible] alive on Sept 1, 1930, and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Carroll R. St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lotary Cemetery DATE OF BURIAL Sept 3 1930

UNDERTAKER Mrs. R. G. Elliott ADDRESS Attendance

Spec.—1-30—M. & T.—250 Bks

0250

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 60250

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital (J. H.)

CITY OF BALTIMORE: (No. 33rd & Calvert ST. 8-13 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Eckles.

(a) RESIDENCE NO. 1114 N. Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 29, 1930.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.-
(State or country)

PARENTS

10 NAME OF FATHER Charles. Eckles.

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Hicks.-

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mother- Dorothy Hicks
(Address) 2216 E. Hamburg St

15 Filed 19[illegible] THAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1/30

17 I HEREBY CERTIFY, That I attended deceased from
Aug. 30, 1930, to Sept. 1st, 1930,
that I last saw him alive on Sept. 1st, 1930,
and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Malnutrition.
(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Francis W. Gluck, M. D.

9/1/1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Elm.

DATE OF BURIAL Sept 3 1930

20 UNDERTAKER Mrs. E. Miller & Son

ADDRESS 2324 Jefferson St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60251

REGISTERED NO. E 60251

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 514 N. Belnord ST., 7-10 WARD) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Brown

(a) RESIDENCE NO. 514 N. Belnord ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced (or) WIFE of Pauline Brown

6 DATE OF BIRTH (month, day, and year) Oct. 31 - 1868

6 AGE Years 61 Months 10 Days 1 If LESS than 1 day, hrs. or min.

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer Phila, Pa.

9 BIRTHPLACE (city or town) (State or country) Phila, Pa.

10 NAME OF FATHER Jacob Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Beaver Pa.

PARENTS

14 Informant (Address) Pauline Brown 514 N. Belnord Ave.

15 Filed SEP 3 - 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2-1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to Sept 2, 1930, that I last saw him alive on Sept 2, 1930, and that death occurred, on the date stated above, at 9P. m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Louis F. Lang, M. D.

9/2, 1930 (Address) 1844 W. Knoxville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Sept. 6 1930

20 UNDERTAKER Wm. E. Miller & Son

ADDRESS 2334 Jefferson Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 E 60252

REGISTERED NO. E 60252

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 915 S. Caroline St. 3-4 Ward)

2-FULL NAME CHRISTIAN WEIGEL

(a) RESIDENCE NO. 915 S. Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Amelia Weigel

6 DATE OF BIRTH (month, day, and year) ? 1850

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	80	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) G
(State or country) Germany

PARENTS

10 NAME OF FATHER John Weigel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Dunkel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Rose Weigel
(Address) 6004 Clear Spring Road

15 Filed P 3 -- 1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Arterio Sclerosis
(duration) unknown yrs. mos. ds.
CONTRIBUTORY (Secondary) Coronary Thrombosis Sudden
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Reuben, M. D.

9-2-1930 (Address) Forest Glen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Paul's Cemetery	Sept. 3 1930
20 UNDERTAKER Henry Sander & Sons, Inc.	ADDRESS Baltimore & Broadway

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60253 ✓ E 60253

CERTIFICATE OF DEATH.

89

REGISTERED NO. 15-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 N. Smallwood ST. WARD)

2-FULL NAME Louis Sklar

(a) RESIDENCE NO. 1814 N. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Israel Sklar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Pearl Silman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Silman

(Address) 1814 N. Smallwood st

15 Filed 3-1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Sept 3, 1930, that I last saw him alive on Sept 3, 1930, and that death occurred, on the date stated above, at 8 — m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. S. Hellman, M. D.

9/3 1930 (Address) 1516 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Road

DATE OF BURIAL Sept 3 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 11-27 E. Balto st

1-30—M & T.—100 B—50L

E 60254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

199 E 60254

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Frederick Ave. St.) (190-69 WARD)

2-FULL NAME Herbert G. Stetter

(a) RESIDENCE NO. 2700 Lauretta Ave. St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	49	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Mfg. Chemist
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Louis E. Stetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Emma J. Parrish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John R. Stetter

(Address) 2700 Lauretta Ave.

15 [illegible] -1930 .192 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide - Skull fractured by a blunt instrument

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke, M. D. Coroner

9/3, 1930 (Address) 3601 Third Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 4 1930

20 UNDERTAKER Chas. H. Black

ADDRESS 742 N. North Ave

Spec.—1-30—M. & T.—250 Bks

Sarah Miles

E 60255

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60255

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Miles

(a) RESIDENCE NO. 932 S. Eutaw St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

6a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-5-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Va.

PARENTS

10 NAME OF FATHER Jacob Rodd

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Va.

12 MAIDEN NAME OF MOTHER Sally Butwells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Va.

14 Informant Records of Baltimore City Hosp.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 3 - 1930 19 By C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-27-30

17 I HEREBY CERTIFY, That I attended deceased from 8-13-29, 19..., to 8-27, 1930,

that I last saw her alive on 8-27, 1930,

and that death occurred, on the date stated above, at 12.45 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Hypertension (duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1. Hospital. 2. Home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget. M. D.

8-28 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS SEP 3 - 1930

20 UNDERTAKER Dept. Commissioner Health.

Spec.—1-30—M. & T.—250 Bks.

240 30 6 E 60256

HEALTH DEPARTMENT—CITY OF BALTIMORE E 60256

CERTIFICATE OF DEATH.

REGISTERED NO. 16108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 15-23 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Spencer

(a) RESIDENCE NO. 1328 N. Carey ST., Ft. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1. 1930

7 AGE: Years | Months | Days | If LESS than 1 day, ½ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Howard Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Marjorie Dalrymple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL Parents (Address)

15 Filed SEP 3 1930, 19 Registrar C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-30

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity

4 hours.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. M. Gaugler, M. D.

9-2 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS SEP 3 - 1930

UNDERTAKER

Commissioner of Health

Spec.—1-30—M. & T.—250 Bks.

2 46 205 E 60257

HEALTH DEPARTMENT—CITY OF BALTIMORE E 60257

CERTIFICATE OF DEATH.

REGISTERED NO. 16,081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jennings

(a) RESIDENCE NO. 453 E-93rd ST., ST WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) Aug 28-30

8 AGE: Years | Months | Days 4 | If LESS than 1 day.....hrs. or.....min.

8a OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER George Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed 9-3-1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1930, to Aug 31, 1930, that I last saw h... alive on Aug 31, 1930, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. C. Geschickter, M. D.

9/2, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 3 - 1930

20 UNDERTAKER

ADDRESS

Commissioner of Health

Spec.—1-10-21—M&T—1500 Blks.

E 60258 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60258

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317½ Lake Ave. ST. 27-48 WARD)

2-FULL NAME Samuel Smith Reynolds

(a) RESIDENCE NO. 317½ Lake Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Reynolds

6 DATE OF BIRTH (month, day, and year) March 19 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. ofl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York State.

PARENTS

10 NAME OF FATHER Samuel Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticut.

12 MAIDEN NAME OF MOTHER Maria Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant D. C. Packard

(Address) 317 ½ Lake Ave

15 Filed 3-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2 1930

17 I HEREBY CERTIFY, That I attended deceased from October 1, 1929, to Sept. 2, 1930, that I last saw him alive on Sept. 2, 1930, and that death occurred, on the date stated above, at 12 50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Cole, M. D.

9-2, 1930 (Address) 6014 York Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Canton Cemetery DATE OF BURIAL Sept 4 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60259

E 60259

CERTIFICATE OF DEATH

REGISTERED NO. 188

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 5004 Belair Rd St. 27 Ward) 41

2-FULL NAME Sophia B. Allard

(a) RESIDENCE NO. 5004 Belair Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Allard

6 DATE OF BIRTH (month, day, and year) Nov. 29th 1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	9	2	

8 OCCUPATION OF DECEASED
(a) Trade, professinn or particular kind of work At Home
(b) General nature nf industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Hanover
(State or country) Germany

PARENTS

10 NAME OF FATHER August Kluber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Willers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Lina H. Mathews
(Address) 5004 Belair Rd.

15 Filed — 1930 — C. E. JAMESON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by automobile while walking across street

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured skull

(duratinn) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In 5000 Block Belair Rd.

Did an nperation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Strauss, M. D.

9 2, 1930 (Address) 2931 Eden

*State the Disease Causing Death, or in deaths frnm Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Sept. 4 1930
20 UNDERTAKER	ADDRESS
Frederick Lansdale Son	7401 Belair Road

Important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60260

E 60260

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2018 Madison av ST. (WARD) 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rudolph Thompson

(a) RESIDENCE NO. 2018 Madison av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Thompson

6 DATE OF BIRTH (month, day, and year): Mar 19, 1885

7 AGE — Years: 45 — Months: 5 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

(c) Name of employer: Lucas Bros, Inc

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Rudolph Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Isabella Foaten

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Minnie Thompson

(Address) 2018 Madison av

15 C. HAMPSON JONES, M.D. Registrar

- 1930 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1930, to Sept 1, 1930, that I last saw h[illegible] alive on Sept 1, 1930 and that death occurred, on the date stated above, at 3.45 P. m. E. S. T.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. M. Hopkins, M. D.

9/2, 1930 (Address) 825 N. Fremont Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: E. Peters Cem. DATE OF BURIAL: Sept 5 1930

20 UNDERTAKER: Samuel Hensley & Bradley ADDRESS 578

Spec. 2-29-28—L. F. S.—500 Bks.

E 60261

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16 E 60261

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 N. Curley ST., 7-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Inman

(a) RESIDENCE NO. 522 N Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 45 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Joseph Inman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Francis H Fulton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Francis Inman

(Address) 522 N Curley

Filed SEP 8 1930 C. HAMPSON JONES, M. D., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1930, to Sept 3, 1930

that I last saw h alive on Sept 3 1930

and that death occurred, on the date stated above, at 1 15 P M

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Leon [illegible] M. D.

9/3, 1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Sept 4 1930

20 UNDERTAKER M. W. E. Deppel Inc — ADDRESS 37 d Conn

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60262

CERTIFICATE OF DEATH

101-901

E 60262

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 917 Washington Blvd Ward 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Knell

(a) RESIDENCE NO. 917 Washington Blvd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Colnr or Raee	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widnwed, or divorced HUSBAND of (or) WIFE of Geo. Knell

6 DATE OF BIRTH (month, day, and year) 7 31 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
78	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession nr particular kind of work Housewife

(b) General nature of industry, business, nr establishment in which employed (or employer) —

(c) Name of emplnyer —

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Geo Knell

(Address)

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1930, to Aug 31, 1930, that I last saw her alive nn Aug. 30, 1930, and that death occurred, on the date stated above, at 7 0'clock P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Klenderworthy M. D.

9/1, 1930 (Address) 642 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial 9/4 1930

20 UNDERTAKER Chas. B. Kuhlmann & Sons ADDRESS 631 S. Paca St

Very important. See instructions on back of certificate.

3

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60263

CERTIFICATE OF DEATH

X 88 E 60263

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Calhoun ST., 14-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Teal

(a) RESIDENCE NO. Sparks, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 10 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Teal

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
5-14			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0-0

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Laban Sparks

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Louis Teal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Teal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Louis Teal

(Address) White Hall Md

Filed 9-8-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-30

17 I HEREBY CERTIFY, That I attended deceased from 8-24, 1930, to 9-3, 1930, that I last saw him alive on 9-3, 1930 and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Acute myocardial failure Arteriosclerotic in origin

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) M. B. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Chapel

DATE OF BURIAL Sept 6 1930

20 UNDERTAKER P. Mankinton

ADDRESS White Hall Md

Spec.—1-30—M. & T.—250 Bks

E 60264

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60264

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1619 E. Preston St. 8-13 WARD)

2-FULL NAME Anna Elizabeth Dengler

(a) RESIDENCE NO. 1619 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. — mos. — ds. How long in U. S., if of foreign birth? 76 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Dengler

6 DATE OF BIRTH (month, day, and year): Feb 4th 1846

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bavaria Germany

PARENTS

10 NAME OF FATHER: John Uhlman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bavaria Germany

12 MAIDEN NAME OF MOTHER: Anna Barbara Uhlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bavaria Germany

14 Informant: Miss Emma Dengler

(Address): 1619 E. Preston St

Filed Sept 3 1930 C. HAMPSON JONES, M. D. Registrar

By Rod

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 2. 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to Sept 3rd 30

that I last saw h er alive on Sept. 2, 1930

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ....yrs. ....mos ....da.

CONTRIBUTORY (Secondary) Anemia & Toxemia

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) Chas Smuck, M. D.

Sept 3 1930 (Address) 4 Northern Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Sept 5 1930

20 UNDERTAKER: Chas. G. Black

ADDRESS: 742 W. Fayette ave

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60265 — 90 E 60265

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 Ware st ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Cook

(a) RESIDENCE NO. 204 Ware ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Cook

DATE OF BIRTH (month, day, and year) 1877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Henry Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant White

(Address) 204 Ware st.

CLAUDSON JONES, M. D. Registrar

FILED 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, at 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 30. 1930. to Sept 1. 1930

that I last saw h/lt alive on Sept 1 1930 7 45 a. m. S.T.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation with Acute Dilatation

(duration) about yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George Mc Donald, M. D.

, 19 (Address) 900 W Franklin St.

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cem.	9/4/1930

20 UNDERTAKER Mrs. Geo. H. Holland ADDRESS 163 Druid Hill Ave

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60266

E 60266

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

2-FULL NAME Irving Pumphrey

(a) RESIDENCE NO. Elkridge, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced (or) HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) July 8-26

8 AGE — Years: 4 Months: 1 Ds.: 24 If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Thomas Pumphrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Grace Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Grace Pumphrey (Address) Elkridge Md

15 Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2-30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1930, to Sept. 2, 1930, that I last saw him alive on Sept. 2, 1930, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia, bilateral

(duration) yrs. mos 13 ds. (approx).

CONTRIBUTORY (Secondary) Pulmonary Edema + myocardial insufficiency (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms + phys. signs

(Signed) H. H. Houchaker, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M. Auburn

DATE OF BURIAL: 9/5/1930

UNDERTAKER: Jno. Geo. H. Kolb

ADDRESS: 1632 Div

pec.—1-30—M. & T.—250 Bks

E 60267

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/VE 60267

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. ST. 17-51 WARD)

2-FULL NAME Joseph Jenkins

(a) RESIDENCE NO. 2220 Oak st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Juanita Jenkins

7 DATE OF BIRTH (month, day, and year) Feb. 8, 1903

8 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27	6	25	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 0-3

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

10 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed 9-3-1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 19 30, to Sept. 3, 19 30, that I last saw him alive on Sept. 3, 19 30, and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Tuberculous pleurisy (duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Lerner, M. D.

9-3, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL 9/6/1930

ADDRESS

20 UNDERTAKER Wm. Geo. E. Holland 1631 Druid Hill Ave

Spec.—1-30—M. & T.—250 Bks

E 60268 HEALTH DEPARTMENT—CITY OF BALTIMORE 66 E 60268

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hosp ST. 12-51 WARD)

2-FULL NAME Mr Edward Halmes

(a) RESIDENCE NO. 2119 Huntingdon Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Baltimore about 1875

8 AGE: Years: about 55 | Months: ? | Days: ? | If LESS than 1 day, ... hrs. or ..... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Work for city

(c) Name of employer City of Baltimore

10 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John W. Halmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John T. Halmes (Brother)
(Address) 5313 Gwynn Oak

15 Filed Sept 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 2, 1930, that I last saw him alive on Sept 2, 1930, and that death occurred, on the date stated above, at 10:00 p.m.

The CAUSE OF DEATH* was as follows:

Subarachnoid hemorrhage
probably arteriosclerotic
origin (C.C. Coroner)

(duration) ..... yrs. 10 mos.

CONTRIBUTORY (Secondary) Acute alcoholism

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Spinal puncture & autopsy

(Signed) Frances W. Glucr, M. D.

9/2/1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem Harford Rd.

DATE OF BURIAL: Sept 5 1930

20 UNDERTAKER: Walter Davis 3418 Gwynns

ADDRESS

Dec. 1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60269

E 60269

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1515 Park ave ST. 14 WARD)

2-FULL NAME Alan Pennemon Smith Jr.

(a) RESIDENCE NO. 1515 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

If married, widowed, or divorced HUSBAND of (or) WIFE of ✓ Divorced

DATE OF BIRTH (month, day, and year) Nov. 16. 1872

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	57	9	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Alan P. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emily Anna Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant E. L. C. Physician

(Address) 1515 Park Ave.

Filed 4-1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3d 1930

17 I HEREBY CERTIFY, That I attended deceased from ..., 1921, to Sept 3d 1930, that I last saw h[illegible] alive on Sept 3d 1930, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Edward Van Ness, M. D.

9-3, 1930 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 9-5 1930

20 UNDERTAKER Henry C. Jenkins Son Co

ADDRESS Orchard & McCulloh

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 60270

E 60270

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 E Lafayette ave ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mina M Eaton

(a) RESIDENCE NO. 1715 E Lafayette ave ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced (or) WIFE of: William H Eaton

DATE OF BIRTH (month, day, and year): March 28th 1867

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	5	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto Co Md

10 NAME OF FATHER: Jacob F Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Martha A Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va

Informant: Howard S. Eaton

(Address) 1715 E. Lafayette ave

Filed ..., 19... Registrar

E. [illegible] JONES, R.

- 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2 1930 to Sept 2 1930

that I last saw h[illegible] alive on Sept 2 1930

and that death occurred, on the date stated above, at 3.08 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 2

Was there an autopsy? [illegible]

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

Sept 3, 1930 (Address) 1854 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Sept 5th 1930

ADDRESS

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 1136 E Monument St

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60271

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 60271

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 So. East Ave ST., 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME JOHANNA KOZLOWSKI,

(a) RESIDENCE NO. 200 So. East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of John Kozlowski,

DATE OF BIRTH (month, day, and year) May -- 1860.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	4		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at home, 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland,

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mrs. Joseph Majewski

(Address) 200 S. East Ave

15 Filed 9-1930 C. EMERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1930, to 9-3-30, 19..

that I last saw h alive on 9-3-30, 19..

and that death occurred on the date stated above, at 3.55 m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

Hypertension

Arteriosclerosis (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Angina (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M.D.

19.. (Address)

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, Cem.

DATE OF BURIAL Sept. 6-1930.

20 UNDERTAKER M. J. Sadowski

ADDRESS 2215 Pelham ave

Spec.—1-30—M. & T.—250 Bks.

E 60272 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 60272

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Maryland Ave ST. 15-21 WARD)

2-FULL NAME Minnie Feinberg

(a) RESIDENCE NO. 1707 Maryland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of Joseph Feinberg

7 DATE OF BIRTH (month, day, and year)

8 AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Feinberg (Mrs.) (Address) 1707 Maryland Ave.

15 Filed 19 C. HARRISON JONES, M. D. Registrar

9-4-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3-1930

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to Sept 3rd, 1930, that I last saw h[illegible] alive on Sept 3, 1930, and that death occurred, on the date stated above, at 6.45 P.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B. Kadin M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash. Road

DATE OF BURIAL 9-4- 19 30

20 UNDERTAKER Jack Kaus, 1139 E Balt. St

ADDRESS

pec.—1-30—M. & T.—250 Bks.

C 60273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

746 ✓ E 60273

REGISTERED NO.

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Eden ST. 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Snee

(a) RESIDENCE NO. 1 Summit Avenue ST. Summit Ave one on Fairfield Rd Catonsville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced (a) HUSBAND of (or) WIFE of Joseph Snee

7 DATE OF BIRTH (month, day, and year) Dec 17 1891

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	7	16	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

10 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Edward Kuto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Joseph Snee

(Address) 1 Summit Ave

15 Filed 4-1930 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-30.

17 I HEREBY CERTIFY, That I attended deceased from 8-28, 1930 to 9-3, 1930,

that I last saw her alive on 9-3-30, 19....,

and that death occurred, on the date stated above, at 11 15 a m.

The CAUSE OF DEATH* was as follows:

Fibroid Uterus

Toxemia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation and Embolism (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 8-29-30.

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) M. Student, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Sept 6 19 30

20 UNDERTAKER Frank Leach & Sons

ADDRESS 926 Cathedral St

pec.—1-30—M. & T.—250 Bks

E 60274 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60274

CERTIFICATE OF DEATH. 117

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 14-20 (WARD)

2-FULL NAME Mary E. Frederick

(a) RESIDENCE NO. 1833 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

6 If married, widowed, or divorced (or) WIFE of Herman A. Fredrick

7 DATE OF BIRTH (month, day, and year) Sept. 12-1892

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset County Maryland

PARENTS

10 NAME OF FATHER James Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Sorene Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset County Md.

14 Informant Herman A. Fredrick (Address) 1833 Bolton

15 Filed 4-1930 C. THOMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1930, to Sept 2, 1930, that I last saw her alive on Sept 2, 1930, and that death occurred, on the date stated above, at 9:12 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis & Appendicitis

(duration) Not definite yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia; Lung Abscess (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 1833 N. Bolton

Did an operation precede death? Yes Date of 8/12/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Edward P. Smith M. D.

9/2 1930 (Address) 920 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 9/6 1930

20 UNDERTAKER J. Few McCully — ADDRESS 1306 E. Fort

Spec. 8-16-29—L. F. S.—100 Pks.

Joseph H Volk

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60275

CERTIFICATE OF DEATH

57 E 60275

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1813 E. Thirty First ST. 9-46 WARD)

2—FULL NAME Joseph H. Volk

(a) RESIDENCE NO. 1813 E. Thirty First ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 24 da. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Emma R. Hayward

DATE OF BIRTH (month, day, and year) Jan. 8 1860

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	7	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Joseph Volk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William E. Volk

(Address) 1813 Thirty First

15 Filed 4 1930 19 C. HAMPSON JONES M. D. Registrar

per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-30

17 I HEREBY CERTIFY, That I attended deceased from June 27 1930 to Sept 2 1930,

that I last saw h[illegible] alive on Sept 2 1930

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Jos. Gray, M. D.

9/3/30 (Address) 1200 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 9/4 1930

20 UNDERTAKER: J. Few McCully — ADDRESS: 1306 E. Fort

Form—6-9-19—H. P. Co.—1000 Blks.

E 60276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60276

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 709 Fairmount ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgiana McDaniel

(a) RESIDENCE NO. 709 Fairmount ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Unknown 1874

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
36!			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William McDaniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) William H. Daniel 709 Fairmount St.

15 Filed SEP 4 - 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 . 1930 . to Sept 1 . 1930

that I last saw her alive on Aug 31 . 1930.

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows: Cardiac & Nervous Exhaustion

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Flowers, M.D.

Sept 3, 1930 (Address) 712 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Sept 4 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

H. JONES M.

Dec.—1-30—M. & T.—250 Bks

E 60277 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60277

CERTIFICATE OF DEATH. 101-004

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Washington Curry

(a) RESIDENCE NO. 6 Wiesenfield Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Frances Curry

7 DATE OF BIRTH (month, day, and year) Unknown 1898

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fish packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Washington Curry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Lizzie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 4 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-30

17 I HEREBY CERTIFY, That I attended deceased from 8-29-30, 19 to 9-1-30, 19

that I last saw him alive on 9-1-30, 19

and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Institution

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos Ghrardelli M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cemetery DATE OF BURIAL 9/4 1930

20 UNDERTAKER George J. Ruth Inc ADDRESS 735 Hanford

Dec.—1-30—M. & T.—250 Bks

60278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 C 60278

REGISTERED NO.

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 723 (Street) Gay ST. 17-26 (WARD)

2-FULL NAME James A. Camper

(a) RESIDENCE NO. 723 Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced (HUSBAND of or) WIFE of Addie Camper

7 DATE OF BIRTH (month, day, and year) Dec, 15-1869

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	28	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Food Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Stephen Camper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Addie Camper (Address) 723 Gay St

15 Filed 4 1930 19 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Sept 2, 1930,

that I last saw him alive on Sept 2, 1930,

and that death occurred, on the date stated above, at 1020 P m.

The CAUSE OF DEATH* was as follows:

Uraemia cystitis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Leary, M. D.

, 19 (Address) 1532 Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL Sept 4, 30

20 UNDERTAKER David E Hensley

ADDRESS 578 N Broadway

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60279

CERTIFICATE OF DEATH

109-002

REGISTERED NO. E 60279

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp St. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Wheeler

(a) RESIDENCE NO. 2206 Hennemans St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) May 20-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	—	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Raymond Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Rose Klimas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Rose Wheeler

(Address) 2206 Hennemans St

Filed ... 1930 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Bronchopneumonia + Adenoid death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Sept 3

Was there an autopsy? Yes X Ray

What test confirmed diagnosis? X Ray

(Signed) H. E. Luck, M. D. Coroner

Sept 3 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hope Cemetery

DATE OF BURIAL Sept 6 1930

20 UNDERTAKER August Paska

ADDRESS 2406 Ashland ave

1-30—M. & T.—100 B—50L

E 60280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

126

REGISTERED NO. E 60280

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 11-27 WARD)

2-FULL NAME Hattie Pinkney

(a) RESIDENCE No 1049 Penna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Courtney Chase

(Address): 1400 Mosher

15 Filed DEC 4-1930 C. HARRISON ELLIS Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Generalized Peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feldis M. D. Coroner

9/4 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill a.a. Co

DATE OF BURIAL: Sept 7 1930

20 UNDERTAKER: Mrs E. A. Parker

ADDRESS: 1400 Mosher

pec.—1-30—M. & T.—250 Bks.

E 60231 HEALTH DEPARTMENT—CITY OF BALTIMORE 60-001 E 60231

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Provident Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1514 Division St. (Ward) 12-51

2-FULL NAME Annie Smith

(a) RESIDENCE NO. 1800 Maryland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

If married, widowed, or divorced (HUSBAND of or) WIFE of Lenderman

DATE OF BIRTH (month, day, and year) Unknown 1880

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Henderson

12 MAIDEN NAME OF MOTHER Lenderman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lenderman

14 Informant Provident Hospt. (Address) 1514 Division St.

15 Filed SEP 4 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31, 30

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930, to Aug 31, 1930, that I last saw h[illegible] alive on Aug 31, 1930, and that death occurred, on the date stated above, at 9.05 p.m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency & dilatation.

(duration) about 6 mos ds.

CONTRIBUTORY (Secondary) Goiter (duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Carroll M. McClain M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL Sept 4 1930

ADDRESS 1725 Ashland Ave

20 UNDERTAKER Mrs. R. G. Elliott

pec.—1-30—M. & T.—250 Blks.

E 60282 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 60282

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 315 Furrow ST. 70-69 WARD)

2-FULL NAME Samuel Burgel

(a) RESIDENCE NO. 315 Furrow ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

6 If married, widowed, or divorced (or) WIFE of Anna Burgel

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cap Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Solomon Burgel
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Yeah –
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 E Balt St.

15 Filed 9-4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3-30

17 I HEREBY CERTIFY, That I attended deceased from 8/25, 1930, to 9/3, 1930, that I last saw him alive on 9/3, 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
Cardiac insufficiency
(duration) yrs. 4 mos ds.
CONTRIBUTORY (Secondary) Acute cardiac dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) Benjamin Marden, M. D.
, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash Rd. DATE OF BURIAL 9-4-1930

20 UNDERTAKER Jack Lewis, 1439 E Balt ADDRESS

pec.—1-30—M. & T.—250 Bks.

E 60283
240449

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001
16 E 662.53

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 27-56 WARD)

2-FULL NAME Baby Rosen

(a) RESIDENCE NO. 3624 Lucille ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	—

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

7 DATE OF BIRTH (month, day, and year) 8-25-30

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	9	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Rosen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

Filed 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1930 to Sept 3, 1930, that I last saw him alive on Sept 3, 1930, and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Jordan, M. D.

Sept, 19 30 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel [redacted]

DATE OF BURIAL Sept 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1434 E Baltimore

pec.—1-30—M. & T.—250 Bks.

23931
ME-60284

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60284

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Glenn

(a) RESIDENCE NO. Edgewood Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
mal	white	single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) 4-2263

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work minister

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed 4 1930 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-30

17 I HEREBY CERTIFY, That I attended deceased from 7-17-, 1930, to 9-3, 1930,

that I last saw him alive on 9-3, 1930,

and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic heart disease (with hypertension; myocardial fibrosis with decompensation)

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7+ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) H. Smith, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Timothy's Catonsville Md

DATE OF BURIAL Sept 5th 1930

20 UNDERTAKER Avery H. Jenkins Sons Co

ADDRESS McCulloh & Orchard Sts.

Spec.—1-12-23—M&T—500 Blks.

E 60285

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60285

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2608 Hoster ave WARD 4-3)

2-FULL NAME Rose Hodges

(a) RESIDENCE NO. 2608 Hester ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edwin Hodges

6 DATE OF BIRTH (month, day, and year): July 23 1879

7 AGE: Years 51 Months Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: George Siedler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Cathrina Betch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Edwin Hodges 2608 Hester ave

15 Filed Sept 3 1930 C. H. JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1930, to Sept 3, 1930, that I last saw h alive on Sept 2, 1930 and that death occurred, on the date stated above, at 2 15 A m

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): none elsa

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O. L. Love, M. D.

9-3, 1930 (Address) 1711 Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem DATE OF BURIAL: Sept 4 1930

20 UNDERTAKER: M. W. E. Dippel & Son ADDRESS: 3. Lan 4

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60286 ✓ E 60286

E 60286

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

City of Baltimore: (No.) Emergency House No 44 St., 17 (Ward) Roland Park

2-FULL NAME John D. Meaker

(a) RESIDENCE NO. 3426 Elm ave St., Ward

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-3-80

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	4	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) Fuel Dealer
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER W. P. Meaker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna McConnell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant J. Meaker
(Address) 3426 Elm ave

Prepared by C. HARRISON JONES, M. D. Registrar

P 4 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis
Disease of
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Harrison Jones, M. D.

9/3/1930 (Address) 3672 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Sept 5 1930

20 UNDERTAKER William G. Schaeffer

ADDRESS 1816 Pennsylvania ave

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60287

CERTIFICATE OF DEATH.

E 60287

REGISTERED NO. 1 1 7

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 76-37 ST., WARD)

2-FULL NAME Emma Wistland Mrs. Frank Fiacha.

(a) RESIDENCE No. North Pt Rd. Balto Co. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of unknown.

7 DATE OF BIRTH (month, day, and year) June 12/1891

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39		2	20	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Factory worker
(b) General nature of Industry, business, or establishment in which employed (or employer) Can Manufacturing
(c) Name of employer Continental Can Co. Baltimore Co.

10 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Adam Lapp.
11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.
12 MAIDEN NAME OF MOTHER Emma Hellman
13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Friends (Address) Baltimore City

15 Filed SEP 4 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-30

17 I HEREBY CERTIFY, That I attended deceased from 8-23-, 1930, to 9-2-, 1930, that I last saw h alive on 9-2-, 1930, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Post operation Coton Pneumonia.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 8-25-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) Fred W. Dunkwalt, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Sept 5/30 19

20 UNDERTAKER Phillips Service — ADDRESS 2016 Eutaw St

Rec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

72 ✓ E 60288

E 60288

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 573 N. Fulton Ave ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph C. Hamilton

(a) RESIDENCE NO. 570 N. Fulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Ella Hamilton

DATE OF BIRTH (month, day, and year): Dec 27-1878

AGE: Years 51 Months 8 Days 6 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: mariner

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer: B & O. R R

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Chas. R. Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Catherine Noble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N Y

Informant: Ella Hamilton

(Address): 573 N Fulton

4 Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2-1930

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to Sept 2, 1930, that I last saw h alive on Sept 2 1930 and that death occurred, on the date stated above, at 8 00 P.M. E.S.T

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia.
Final Hemorrhage. Perhaps from water dam

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Wassermann

(Signed) Edward C Cook M. D.

9/2 1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

UNDERTAKER: Edw. F. Fanning & Son

DATE OF BURIAL: Sept 5 1930

ADDRESS: Lafayette & Washington

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60289

CERTIFICATE OF DEATH

168 E 60289

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced Dead at Balto City Hospital

City of Baltimore: (No. ..... St., ... Ward)

2-FULL NAME Rudolph Engnoth

(a) RESIDENCE NO. 2923 Hudson St., ... Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Kate Engnoth

6 DATE OF BIRTH (month, day, and year) May 16 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53	3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Carl F Engnoth

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Eleonore Mantz

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Kate Engnoth
(Address) 2923 Hudson St

15 Filed ..... 19.. ..... Registrar

4-1930 C. HAMSON JONES, M. D.

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by Hanging Suicidal while Insane

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

9.4.1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz cemetery	Sept 7 1930
20 UNDERTAKER	ADDRESS
George W. Zirkler	1737 E Eager St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60290

CERTIFICATE OF DEATH

X 197

E 60290

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals St. 76-37 Ward)

2-FULL NAME Elmer Holland

(a) RESIDENCE NO. Cowenton-Red Lion Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Christina M. Holland

6 DATE OF BIRTH (month, day, and year)
May 30th. 1889.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER James H. Holland

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Mollie Addison

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Harford Co., Md.

14 Informant Christina M. Holland
(Address) Fullerton P.O. Md.

15 Filed ..... 19.. C. PEARSON JONES, M. D. Registrar
Sept 6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gun Shot Wound
Through Brain from R & R
murder
(duration) 5m yrs. 3 mos. 3 Ds

CONTRIBUTORY (Secondary) Hemorrhage into Brain (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James H Revelos M. D.

Sept 4 1930 (Address) 705 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ebenezer Cemetery

DATE OF BURIAL Sept. 6 1930

20 UNDERTAKER Fred Leasdon Sons

ADDRESS 7401 Belair Rd.

Cor.—10-10-29—A Co.—100 Bks.

E 60291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

7-188 203 ✓ E 60291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Josephs Hospital St., 9-17 Ward)

2-FULL NAME William J. Toboll

(a) RESIDENCE NO. Kenwood & Elinor Ave. Raspeburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna C. Toboll

6 DATE OF BIRTH (month, day, and year) December 22nd, 1898

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Toboll

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Anna C. Toboll
(Address) Kenwood & Elinor Aves.

15 1930 C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:
Walked into path of moving auto
@
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract. Skull Multiple
Fract Ribs - Pneumothorax
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Belair Rd (Co)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray Examination

(Signed) H. Braun M. D.

9/3 1930 (Address) 29 39th W Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Sept. 6 1930

20 UNDERTAKER Fred Lassahn Sons

ADDRESS 7401 Belair Rd.

Ent

1-30—M. & T.—100 B—50L

E 60292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60292

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4000 (Street) Harrington (WARD) 24

2-FULL NAME Herman H Duker

(a) RESIDENCE No. 4000 (Usual place of abode) St. Paul WARD .....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose H Duker

6 DATE OF BIRTH (month, day, and year): Apr 4, 1859

7 AGE: Years 71 | Months 5 | Days | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lumber + Millwork
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Otto Duker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Radicker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Henry S Duker

(Address): 1001 N Charles St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos ... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Inquiry

(Signed) G. Gelpcke, M. D. Coroner

19 (Address) 1113 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fremont Cemetery

DATE OF BURIAL: 10/5/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60293

E 60293

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp. ST. 1-6-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Nugent

(a) RESIDENCE NO. 2521 W. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced: HUSBAND of (or) WIFE of Nellie C. Nugent

DATE OF BIRTH (month, day, and year) Oct 8-1876

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lunch Room Work

(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

(c) Name of employer: Self

BIRTHPLACE (city or town) (State or country): Balto County Md

10 NAME OF FATHER (Unknown) Nugent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Nellie C. Nugent (Address) 2521 W. Lafayette Ave

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

1930 22273

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 2, 1930, that I last saw h[illegible] alive on Sept 2 1930 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic
Arteriosclerosis - Hypertension
Nephritis, Chronic Interstitial

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Stuley Jr, M. D.

, 19 (Address) Bon Secours Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: 9/6 1930

20 UNDERTAKER: P. Wm Cook

ADDRESS: 1217 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

E 60294

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60294

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2005 Cedley St. Westport. ST., 05-32 (WARD)

2-FULL NAME Stephen M.D. Mesz.

(a) RESIDENCE NO. 2005 Cedley St. Westport. ST., .WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Oct. 16° 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	68	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman. 62

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Novelty Steam Bdlr. Wks.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Mesz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Schnehl.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John Mesz. (nephew)
(Address) 820 W. Hamburg St.

15 Filed 4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Ougust 20th 1930 . to September 3rd 1930 .

that I last saw him alive on September 3rd 1930

and that death occurred, on the date stated above, at 10.45 a.m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. mos. 21 ds.

Uraemia.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Sig.) Otto M. Reinhardt, M. D.

9/4, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park. DATE OF BURIAL 9/5 1930

20 UNDERTAKER William Cook ADDRESS 1217 E. Pool St

Cor.—10-10-29—A Co.—100 Bks.

E 60295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 101-001 ✓ E 60295

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balt City Hospital St. 16-22 (Ward)

2-FULL NAME Estella Moody

(a) RESIDENCE NO. 1113 Whetcoat St., Ward (If non-resident give city or town and State) New York City

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Denis Moody

6 DATE OF BIRTH (month, day, and year) Feb 1, 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	38	7	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waitress
(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant
(c) Name of employer

9 BIRTHPLACE (city or town) Charles Co
(State or country) Md

PARENTS

10 NAME OF FATHER Richard Wood

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Fannie Owens

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Curacaunda

14 Informant Henry Dennis
(Address) 715 Arlington

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Bullock M. D.

9.4.1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 9-6 1930

20 UNDERTAKER George W Gibson

ADDRESS 1135 40 Gibson

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60296

60296

CERTIFICATE OF DEATH.

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Agnes Hospital ST., 19-26 WARD)

2-FULL NAME Clifton Paul Llewallyn

(a) RESIDENCE NO. 1305 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): 9-0-30

7 AGE — Years — Months — Days — If LESS than 1 day, 12 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Bruce Llewallyn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Athens Georgia

12 MAIDEN NAME OF MOTHER: Hilda Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): Mrs Hilda Llewallyn 1305 Hollins St

15 Filed 19 30 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-4 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-3 .1930. to 9-4 .1930.

that I last saw h[illegible] alive on 9-4 .1930.

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of new-born

(duration) yrs. mos 12 hrs

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frances L Rodgers M. D.

, 19 (Address) 1117 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Sept 5 1930

20 UNDERTAKER: W. J. Teckmeyer & Son

ADDRESS: North & Pa

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60297

E 60297

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH Mercy Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5-8 ST. WARD)

2-FULL NAME Robert Sweeney

(a) RESIDENCE No. Levering House ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) April 17

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
(48)	38			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Selling Papers

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Mass.

10 NAME OF FATHER Chas Sweeny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-30

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to Aug 31, 1930, that I last saw h[illegible] alive on Aug 31/1930, and that death occurred, on the date stated above, at 11[10] P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Lobular Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko M. D.

9/1/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 4 - 1930

20 UNDERTAKER C. THOMPSON JONES, M. D.

ADDRESS

4 - 1930

Spec.—1-30—M. & T.—250 Bks.

E 60298

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60298

CERTIFICATE OF DEATH

74-002

1-PLACE OF DEATH South Baltimore General Hospital REGISTERED NO. 1668

CITY OF BALTIMORE: (No. ..... St. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Kearsey

(a) RESIDENCE NO. 833 Poplar Grove ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6-7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

6 If married, widowed, or divorced HUSBAND of or) WIFE of John David Kearsey

DATE OF BIRTH (month, day, and year) Jan. 3, 1865

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	8	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Harford County
(State or country) Maryland

10 NAME OF FATHER J. Daughton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Pruitt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Loretta Dell
(Address) 833 Poplar Grove St.

15 Filed 1930 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 4, 193

17 I HEREBY CERTIFY, That I attended deceased from August 29, 1930 to September 4, 1930. that I last saw her alive on September 4, 1930. and that death occurred, on the date stated above, at 8 05 A m.

The CAUSE OF DEATH* was as follows:

Acute cholecystitis; auricular fibrillation

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. Sullivan M. D.

9/4/, 1930 (Address) So Balti Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept. 6 1930

20 UNDERTAKER Geo. B. Cook

ADDRESS 1003 West Baltimore St

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60299

CERTIFICATE OF DEATH.

154-E 60299

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1722 N. Castle ST. 8-17 (WARD)

2-FULL NAME Matilda Ellen Wemiltt

(a) RESIDENCE NO. 1722 N Castle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

6 If married, widowed, or divorced: HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year): Aug. 29, 1929

8 AGE: Years: 1 — Months: — Days: 5 — If LESS than 1 day, hrs. or min.: —

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Henry Lawrence Wemiltt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Martha H. Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Henry Lawrence Wemiltt.
(Address) 1722 Castle St.

15 Filed: 1930 19 Registrar: THOMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-4 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/1/30 er, 1930, to 9/4, 1930, that I last saw h alive on 9/4, 1930 and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis Staphylococcus

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical sign

(Signed) Paul Miller, M. D.

9/4, 1930 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill A.A. | DATE OF BURIAL: 9/5 1930

20 UNDERTAKER: Frederick A. Cole | ADDRESS: 120 W. Fayette

Spec.—1-10-21—M&T—1500 Blks.

E 60300

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60300

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3915 Roland Ave ST., 13 WARD)

2-FULL NAME James B. Johnson

(a) RESIDENCE NO. 3915 Roland Ave ST., 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Johnson

6 DATE OF BIRTH (month, day, and year): Sept. 9-1863

7 AGE: Years 67 — Months 4 — Days 24

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer): Gardener

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Smith Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Eliz. Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Jas B Johnson 3915 Roland

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 3 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Sept 3, 1930, that I last saw h— alive on Sept 3, 1930, and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. J. Englert M. D.

(Address) 3701 Roland Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden — DATE OF BURIAL: Sept 6 1930

20 UNDERTAKER: Chas Weldon Son — ADDRESS: 3616 Chestnut

1-30—M. & T.—100 B—50L

E 60301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓ E 60301

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hopkins Hospital (Ward) St 2-4

2-FULL NAME Tadeusz Dlabich

(a) RESIDENCE NO 113 S. Ann ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15/1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	0	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md
(State or country)

PARENTS

10 NAME OF FATHER Wactaw Dlabich

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Kalicanski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Wactaw Dlabich
(Address) 113 S. Ann St.

15 Filed ..... C. HAMPSON JONES, M. D. Registrar
- 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 3/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pneumonia- probably Broncho pneumonia

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical at hospital

(Signed) H. H. Watters, M. D.
Coroner

9/4/30, 19 (Address) 2208 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove Cemetery

DATE OF BURIAL 9/6, 19 30

20 UNDERTAKER Peter Wolf

ADDRESS 1000 Wolfe St

Cor.—10-10-29—A Co.—100 Bks.

E 60302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66

E 60302

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 8-17 Ward)

2-FULL NAME Barrington J. Mc Allister

(a) RESIDENCE NO. 1736 N. Bond ? St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (Write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1888

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
42	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town) N. Y.
(State or country)

PARENTS

10 NAME OF FATHER W. C. Mc Allister

11 BIRTHPLACE OF FATHER (city or town) N. Y.
(State or country)

12 MAIDEN NAME OF MOTHER M. L. Bourne

13 BIRTHPLACE OF MOTHER (city or town) N. Y.
(State or country)

14 Informant G. B. Mc Allister
(Address) 4700 Eden 4107 Eden 22.

15 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Riley M. D.

Sept 4 1930 (Address) 1657 Bonaparte

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Sept. 5 1930

20 UNDERTAKER Wm. C. Black 927 N. Broadway ADDRESS

...ec.—2-29-28—L. F. S.—500 Bks.

E 60303

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 60303

CERTIFICATE OF DEATH

1—PLACE OF DEATH Sieling Sanitarium

REGISTERED NO. 1

CITY OF BALTIMORE: (No. 600 S. Chapel Gate La. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry J. Trinkaus

(a) RESIDENCE NO. 218 S. Augusta Ave., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna F. Trinkaus

DATE OF BIRTH (month, day, and year) Aug. 1, 1847

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	1	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

BIRTHPLACE (city or town)
(State or country) Maryland

10 NAME OF FATHER Michael Trinkaus

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Miss Mary Trinkaus

(Address) 218 S. Augusta Ave.,

Filed ... 19 ... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 25th. 19 29 to Sept. 1st. 1930, that I last saw him alive on Sept. 1st. 1930 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. Neveleman M. D.

9/4 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	9/5 1930
20 UNDERTAKER	ADDRESS
George Farley	Fulton & Fayette St.

Dec.—1-30—M. & T.—250 Bks

E 60304 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60304

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital. REGISTERED NO. 113

CITY OF BALTIMORE: (No. 4-1 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otis Mills

(a) RESIDENCE NO. Gunthicum Heights ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) May 9/30

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~~35~~	3	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Hinton Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gillis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Hospital Records

(Address)

15 Filed 5 1930, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29-30

17 I HEREBY CERTIFY, That I attended deceased from 8-11, 1930, to 8-29, 1930,

that I last saw h alive on 8-29, 1930,

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Ulcero colitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinic

(Signed) J Leyko, M. D.

9/1/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet

DATE OF BURIAL 9-5 1930

20 UNDERTAKER Mr-Mrs R S Tenk

ADDRESS 2512 Walbrook Ave

-30—M. & T.—100 B—50L

E 60305

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60305

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5205 Lindenedale ST. 28-21 WARD)

2-FULL NAME Emma M. Dailey

(a) RESIDENCE NO. 5205 Lindenedale St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of H. Edward Dailey

6 DATE OF BIRTH (month, day, and year) June 9th 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	2	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .. H W
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas. A. Jacobi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Victorine Boldmeier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant H. S. Dailey

(Address) 5205 Lindenedale

15 Filed ..... 1930 ..... 19..... THOMPSON JONES, Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. A. Jacobi, M. D. Coroner

Sept 3, 1930 (Address) Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 9/5 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

-30—M. & T.—100 B—50L

E 60306

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60306

CERTIFICATE OF DEATH

REGISTERED NO. 1857

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE, (No.) Maryland Gen Hospital St. WARD 16

2-FULL NAME Joseph F. Carey

(a) RESIDENCE NO 2931 Pressman WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 9-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	6	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph J Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catharina Carns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John J Carey (Address) 2931 Pressman

15 Filed SEP 5 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 4th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Concussion of brain

Fell (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 9-8 1930

UNDERTAKER Williams Cook

ADDRESS 1217 St Paul St

rec.—1-30—M. & T.—250 Bks.

E 60307

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60307

CERTIFICATE OF DEATH.

REGISTERED NO. 18-29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1132 W Pratt ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna B. Smith.

(a) RESIDENCE NO. 1132 N Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

If married, widowed, or divorced (HUSBAND) of (or) WIFE of none.

DATE OF BIRTH (month, day, and year) Oct 5 1879

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	10	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Box Factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

19 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sophia Bornkrend

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Sophia Smith.

(Address) 1132 N Pratt St

15 FILED 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/30, 1930, to 9/3/30, 19...,

that I last saw h... alive on 9/3/30, 19...,

and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Ch. Diff Lupus

(duration) forty yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Samuel J. Levy, M. D.

9/4/1930 (Address) 9 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C.C. Co. DATE OF BURIAL Sept. 6th 1930

20 UNDERTAKER Bernard C Harle ADDRESS 1000 S Paca St.

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60308

E 60308

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 22-30 WARD)

2-FULL NAME William Johnson

(a) RESIDENCE NO 137 W. Camden ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie Johnson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ala.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Addie Johnson
(Address) 137 W. Camden St

15 Filed ... 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull.
Accidental Death.
(duration) ... yrs. mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Eugene Zeller, M. D. Coroner

9/5, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 9/5 1930

20 UNDERTAKER Daniel Easton — ADDRESS 911 Penna Ave

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60309

CERTIFICATE OF DEATH

161-001

E 60309

REGISTERED NO. .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 N. Mount ST. 19-27 (WARD)

2-FULL NAME Infant Jenkins

(a) RESIDENCE NO 211 N Mount ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1-1/2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Wm Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Elanora Foreman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Mother

(Address) 211 N. Mount

15 Filed SEP 5 1930 ROBT. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematura Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thos. H. Brooke, M. D. Coroner

Sept 4, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn

DATE OF BURIAL Sept 5 1930

20 UNDERTAKER Joseph A. Lively

ADDRESS 4099 Mount Street

Dec.—1-30—M. & T.—250 Bks.

2110324

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60310

E 60310

CERTIFICATE OF DEATH.

REGISTERED NO. 70

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 15-21 WARD)

2-FULL NAME Annette Ehrlich

(a) RESIDENCE NO. 2025 N Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 8-1917

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	11	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Edward

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Y

12 MAIDEN NAME OF MOTHER Minnie Dazield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed 5 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1930 to Sept 4, 1930, that I last saw h[illegible] alive on Sept 4, 1930, and that death occurred, on the date stated above, at 11.55 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral abscess

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Caroline C. Bidell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 9-5- 19 30

UNDERTAKER Jack Levin, 1439

ADDRESS Eden St

-30—M. & T.—100 B—50L

E 60311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 60311

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Providence Hosp. ST. 6-9 (WARD)

2-FULL NAME John Vincent Harris

(a) RESIDENCE NO 18 N. Durham St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgie Harris

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary Lee Md

PARENTS

10 NAME OF FATHER Solomon Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Georgie Harris
(Address) 18 N. Durham

15 Filed SEP 5 1930 H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia.

Chronic Nephritis (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Sudden (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Edward Hebb M. D.

Sept 3 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL Sept 7 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

Dec.—1-30—M. & T.—250 Blks

E 60312 HEALTH DEPARTMENT—CITY OF BALTIMORE 46E 60312

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 112 N. Monroe ST. 20-27 WARD)

2-FULL NAME Laura Virginia Harris

(a) RESIDENCE NO. 112 N. Monroe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Harris

DATE OF BIRTH (month, day, and year) Nov. 10, 1851

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	26	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Co. Md.

10 NAME OF FATHER Samuel Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Ann Garlner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Rev. P. L. Wright
(Address) 112 N. Monroe St.

15 Filed Dec 1 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Aug 3, 1930,
that I last saw her alive on Aug 2, 1930,
and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus + Asthenia.
(duration) 3 or 4 yrs. — mos — da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) W Bowman Reed, M. D.
9/3, 1930 (Address) 2216 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown Md. Asbury Cem.
DATE OF BURIAL Sept 5 1930
UNDERTAKER W. H. Fletcher Sons
ADDRESS North & Pa

Form —1 30— M. & T.—250 Bks.

E 60313 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 60313

CERTIFICATE OF DEATH.

REGISTERED NO. 4

1-PLACE OF DEATH (If death occurred in hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Sydenham Hospital

2-FULL NAME Irving Armiger, Jr.

(a) RESIDENCE NO. 1528 Jackson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 11, 1929.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Irving Armiger

11 BIRTHPLACE OF FATHER (city or town) Dkalb
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Howe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Irving Armiger
(Address) 1528 Jackson Street

Filed SEP 5 - 1930 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930 to Sept 4, 1930, that I last saw him alive on Sept 4, 1930, and that death occurred, on the date stated above, at 6:05 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1528 Jackson St.

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Laboratory

(Signed) Joseph K. Sham M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem. DATE OF BURIAL Sept 6 1930

UNDERTAKER E. Howard Evans ADDRESS 38 E Hoffman Ave

Dec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

60314

REGISTERED NO. E 60314

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2014 E. Madison ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth S. Appel

(a) RESIDENCE NO. 2014 E. Madison ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Appel

DATE OF BIRTH (month, day, and year) Aug 2/1867

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	1	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry Appel

(Address) 2014 E Madison St

15 Filed Sept 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 3, 1930, that I last saw her alive on Sept 3, 1930, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Richard L. Koerner, M. D.

Sept. 19 30 (Address) 1301 W Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Sept 6/30

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Eutaw St

ec.—1-30—M. & T.—250 Bks

E 60315

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60315

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 Ausquith ST. 10-14 WARD)

2-FULL NAME Annie Stafford

(a) RESIDENCE NO. 904 Ausquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	C	Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Keegan Stafford

DATE OF BIRTH (month, day, and year) [illegible] 1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) md

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) unk

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unk

14 Informant for Stafford
(Address) [illegible]

15 Filed [illegible] 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Sept 2, 1930, that I last saw h[illegible] alive on Sept 2, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cardio Renal

(duration) yrs. mos 30 da.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? unk

Did an operation precede death? unk Date of —

Was there an autopsy? unk

What test confirmed diagnosis? yes

(Signed) [illegible], M. D.

Sept 2, 1930 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Sept 5 1930
20 UNDERTAKER Mrs Ida Mendes	ADDRESS 1708 E Monument

-30—M. & T.—100 B—50L

E 60316

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60316

CERTIFICATE OF DEATH

REGISTERED NO. 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. Rear 4000 Block Gorman ST. 15-16 WARD

2-FULL NAME Earl Wright Shatter

(a) RESIDENCE No. 4008 Oakford ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Shatter

6 DATE OF BIRTH (month, day, and year): May 5-1900

7 AGE: Years 30 | Months 3 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Auto Salesman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Trenton N. J.

PARENTS

10 NAME OF FATHER: John F. Shatter

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Gertrude Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant: Josephine Shatter

(Address): 4008 Oakford

15 Filed SEP 5 1930

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide
Asphyxia.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carbon Monoxide Gas
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Garage Rear 4000 Block Gorman St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inquest

(Signed) H. Leo Feldenheimer M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

UNDERTAKER: Joseph B Cole

DATE OF BURIAL: Sept 6th 1930

ADDRESS: 1003 W Balto St

pec.—8-16-29—L. F. S.—100 Bks.

E 60317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

E 60317

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Eastern Ave. ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Frankowski Jr.

(a) RESIDENCE NO. 2108 Eastern Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 30 — 28

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	11		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Walter Frankowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Sadowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Walter Frankowski

(Address) 2108 Eastern Ave.

Filed [illegible] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 — 30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1930, to Sept. 3, 1930, that I last saw him alive on Sept. 3, 1930, and that death occurred, on the date stated above, at 9. A. m.

The CAUSE OF DEATH* was as follows:

Acute Entero - Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Accidents

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/3, 1930 (Address) 1930 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Rosary

DATE OF BURIAL

Sept. 6 1930

UNDERTAKER

J. W. Bazowski

ADDRESS

1930 Eastern Ave

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 60318

60318

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1606 E. Lanvale St. (8-17 Ward)

2-FULL NAME Albert Pike Bennett

(a) RESIDENCE NO. 1606 E Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anne T. Bennett

6 DATE OF BIRTH (month, day, and year): 9-1858

7 AGE: Years 71 Months 9 Days 24 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Daniel K. Bennett

11 BIRTHPLACE OF FATHER (City or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Melissa Hewitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Mrs. James Hays.

15 Filed P 5 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 3 1930

17 I HEREBY CERTIFY, That I attended deceased from October, 1928, to September 3, 1930, that I last saw him alive on September 3, 1930, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Roentgen-Ray

(Signed) Edgar P. Sandrock M. D.

(Address) Medical Arts Building

Sept 8 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial Sept 5-

20 UNDERTAKER: E. J. Fanning & Son ADDRESS 1938 E.

2-29-28—L. F. S.—500 Bks.

E 60319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 74-001 E 60319

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2088 S. Augusta ave ST. 20-71 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James C. Kearney

(a) RESIDENCE NO. 205 S. Augusta ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ella McKeever

6 DATE OF BIRTH (month, day, and year): July 28, 1874

7 AGE: Years: 56 | Months: | Days: 6 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): National Casket Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

10 NAME OF FATHER: James D. Kearney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Mrs. James C. Kearney

(Address) 205 S. Augusta ave

Filed ..... 19 30 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3, 1930

17 I HEREBY CERTIFY That I attended deceased from July 28 30, 19..., to Sept 3, 19 30, that I last saw him alive on Sept 3, 1930, and that death occurred, on the date stated above, at 1 30 P.m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 30 (Address) 120 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Sept 6, 1930

20 UNDERTAKER: John A. Moran

ADDRESS: 5000 E Baltimore

Einolf

E 60320

117

60320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph's Hospital ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Einolf

(a) RESIDENCE NO. 2664 Kennedy Ave ST., WARD Cheshire

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	S.

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) June 27-1915

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	2	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Harry Einolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mary Grossman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mary Einolf (Address) 2644 Kennedy Ave

Filed 5-1930 H. LAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 3rd, 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-1, 1930, to 9-3, 1930, that I last saw h[illegible] alive on September 3rd, 1930, and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendicitis

Peritonitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-2-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wm. Lucas, M. D.

(Address) 2644 Kennedy Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 9/6/30

20 UNDERTAKER J. J. Moran

ADDRESS 3000 Baltimore

sec.—1-30—M. & T.—250 Bks.

60321

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 60321

REGISTERED NO.

1-PLACE OF DEATH U. S. Marine Hospital, Baltimore, Md. 27-56

CITY OF BALTIMORE: (NO. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Howard

(a) RESIDENCE NO. 2803 Santa Fe Avenue, Baltimore, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Essie Regner

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66		29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Seaman

(c) Name of employer SS Senator

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Jefferson Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant U.S.Marine Hospital Records

(Address) Baltimore, Maryland.

15 Filed 9 - 1936 HARRISON [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept.4,1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to Sept. 4, 1930, that I last saw him alive on Sept. 4, 1930, and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the prostate with metastasis in the pelvis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & x-ray findings

(Signed) J.H.R. Booth D.D. M. D.

, 19 (Address) U.S.Marine Hospital, Balto., Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lauden Park

DATE OF BURIAL Sept 5, 1930

20 UNDERTAKER John A. Inman

ADDRESS 3000 E. Balto St.

ec—1-30—M. & T.—250 Blks.

C 60322 HEALTH DEPARTMENT—CITY OF BALTIMORE 24-001 60322

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME Michael Schaefer

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Susanna Schaefer

DATE OF BIRTH (month, day, and year) Dec 5th 1851

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	8	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country)

10 NAME OF FATHER Valentine Schaefer

11 BIRTHPLACE OF FATHER (city or town) Not Known

(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

Informant Little Sisters of the Poor

(Address) Preston & Valley

Filed 5 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1930, to Sept 4, 1930, that I last saw h[illegible] alive on Sept 3, 1930, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Internal Capsule with Hemiplegia)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteric Sclerosis (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Thos. R. Geraghty M. D.

9/5, 1930 (Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Sept 8 1930

20 UNDERTAKER Henry Hoede & Sons Inc.

ADDRESS 1304 E. Eager St

...c.—1-30—M. & T.—250 Blks

E 60323 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60323

CERTIFICATE OF DEATH. 118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

2-FULL NAME David A Backman

(a) RESIDENCE NO. Taneytown, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Backman

DATE OF BIRTH (month, day, and year) Aug 15, 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Geo F. Backman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Bowds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Charles F. Backman

(Address) New Windsor Md

Filed 1930 C. HARPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 5, 1930, that I last saw him alive on Sept 5, 1930, and that death occurred, on the date stated above, at 10.00 a. m.

The CAUSE OF DEATH* was as follows:

Strangulated Ist inguinal hernia (duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Hernia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Sept 4, 1930

Was there an autopsy? No

What test confirmed diagnosis? operation + catheterization

(Signed) Geo F. Backman, M. D.

, 19 (Address) Taneytown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Taneytown Lutheran DATE OF BURIAL Sept 9 1930

20 UNDERTAKER C. O. Smaltzer ADDRESS Taneytown Md

Rec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 ✓ E 60324

[redacted].

E 60324

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3204 Tate St. (Ward) Garfield 25-16

2—FULL NAME Mrs Carrie Johnson Mccarraga

(a) RESIDENCE NO. 3204 Tate ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

If married, widowed, or divorced HUSBAND of (or) WIFE of: Mccarraga

DATE OF BIRTH (month, day, and year): Aug 24 1930

AGE: Years — Months — Days — If LESS than 1 day, hrs. or 5 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Garfield Md

10 NAME OF FATHER: Frank Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Ella Shuford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

Informant: Husband

(Address): 3204 Tate St

C. HAMPSON JONES, M.D.

Registrar

AUG 30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1930, to Aug 29, 1930, that I last saw h[illegible] alive on Aug 29, 1930, and that death occurred, on the date stated above, at 6½ m.

The CAUSE OF DEATH* was as follows:

Mercarraga

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. McDonald M. D.

(Address) 1900 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL: AUG 30 1930

20 UNDERTAKER

ADDRESS

[redacted] Johns Hopkins Hospital

Baltimore Health.

1-30—M. & T.—250 Blks.

E 60325 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60325

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3314 Batavia Ave (St.) 27-41 (Ward)

2-FULL NAME Lida C. Schuster

(a) RESIDENCE No. 3314 Batavia Ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Schuster

DATE OF BIRTH (month, day, and year) Sept. 20-1883

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	11	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Washington D.C.

10 NAME OF FATHER Charles Suehle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emelia Kuper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

Informant Charles W. Schuster

(Address) 3314 Batavia Ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1927, to Sept. 4, 1930, that I last saw h[er] alive on Sept. 3, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus + Cancrum.

(duration) yrs. 18 mos ..... ds.

CONTRIBUTORY (Secondary) General Metastases

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of March 1924

Was there an autopsy? No

What test confirmed diagnosis? Pathology Lab

(Signed) Allen A. Zinsser, M. D.

9/4/1930 (Address) 6137 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 6 1930

20 UNDERTAKER E. J. Fanning & Son — ADDRESS 1738 Eutaw Place

ec.—1-30—M. & T.—250 Bks.

240332

E 60326

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60326

CERTIFICATE OF DEATH.

161-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 1-3 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Albrecht

(a) RESIDENCE NO. 831 S - Lakewood St., 9th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

If married, widowed, or divorced: HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 2 - 1930

AGE: Years ... Months ... Days ... If LESS than 1 day, 7 hrs. or ... min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Peter Albrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant (Address) JOHNS HOPKINS HOSPITAL Records

Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 2, 1930, that I last saw her alive on Sept 2, 1930, and that death occurred, on the date stated above, at 6 55 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. G. Gordon, M. D.

9 mo. 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: SEP 5 1930

20 UNDERTAKER: Undertaker Realty

ADDRESS

- 1930

30—M. & T.—100 B—50L

E 60327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

160 E 60327

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 S. Grove ST. 22-30 WARD)

2-FULL NAME Gilbert Dailey

(a) RESIDENCE NO 613 S. Grove ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Gilbert Dailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant .....
(Address)

15 Filed ..... 192 ..... Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible] Coroner, M. D.

9/3 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL SEP 19 1930

20 UNDERTAKER [illegible]

ADDRESS

G. HAMPSON JONES, M. D.
Commissioner Health

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60328

CERTIFICATE OF DEATH

179 E 60328

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

ITY OF BALTIMORE: (No.) 780 N. Mulberry ST. 18-10 (WARD)

2—FULL NAME Willie Lowery

(a) RESIDENCE NO. 780 N. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel Lowery

DATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Geo. Mantiply

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Edward Mantiply

(Address) .....

File 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2 30

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to Sept. 2, 1930, that I last saw h[illegible] alive on Aug. 30, 1930, and that death occurred, on the date stated above, at 12:55 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 4 mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Duppins M. D.

9/2/30 (Address) 1012 N. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19 .....

20 UNDERTAKER Commissioner Health

ADDRESS SEP[illegible] - 1930

HE MORGUE.

ec.—1-30—M. & T.—250 Bks.

E 60329

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60329

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST. 10-14 WARD)

REGISTERED NO. 161-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Eskridge

(a) RESIDENCE NO. 811 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 25th 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Balto
(State or country) Md

10 NAME OF FATHER Robert Eskridge

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Jackson

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant
(Address) Johns Hopkins Hospital

Filed 5 - 1930 19 ACH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-25-, 19 30, to 8-29-, 19 30,

that I last saw him alive on 8-29-, 19 30,

and that death occurred, on the date stated above, at 1 00 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobular pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E P H Harrison Jr., M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

Commissioner Health

ADDRESS SEP 5 - 1930

...c.—1-30—M. & T.—250 Bks.

60330

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60330

CERTIFICATE OF DEATH.

REGISTERED NO. 1627

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ... ST., ... (WARD)

2-FULL NAME Baby boy Hawkins

(a) RESIDENCE NO. ... ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced (or) WIFE of ... HUSBAND of

DATE OF BIRTH (month, day, and year) 9-5-30.

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 8 min.
	0	0	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

BIRTHPLACE (city or town) (State or country) ...

10 NAME OF FATHER ...

11 BIRTHPLACE OF FATHER (city or town) (State or country) ...

12 MAIDEN NAME OF MOTHER ...

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ...

14 Informant ... (Address) ...

15 Filed ..., 19... Registrar ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-5-30.

17 I HEREBY CERTIFY, That I attended deceased from 9-5-30, 19..., to 9-5-30, 19..., that I last saw h... alive on 9-5-30, 19..., and that death occurred, on the date stated above, at 3,38[illegible]m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) W B Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lutherville Md.	Sept 5 19 30
20 UNDERTAKER	ADDRESS
Rieve & Son Inc	Lutherville

Cor.—10-10-29—A Co.—100 Bks.

(Deal)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60331

CERTIFICATE OF DEATH

90 E 60331

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St., 16-68 Ward)

2-FULL NAME Edward B. Deal

(a) RESIDENCE NO. 2437 Monahan Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jno Deal

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mc Kinney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs B Deal
(Address) 2537 Monah. Ave

15 Filed 19 CAMPBELL JOHNSON Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. disease heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. T. Berry, M. D.

Sept 5, 1930 (Address) 1659 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park cem

DATE OF BURIAL Sept 8 1930

20 UNDERTAKER Geo. W. Settle

ADDRESS 2700 Edmondson Ave

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60332

CERTIFICATE OF DEATH

REGISTERED NO. E 60332

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3021 Northway ST. 27-43 WARD

2-FULL NAME Lee August Drake

(a) RESIDENCE NO 3021 Northway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Naomi Drake

6 DATE OF BIRTH (month, day, and year) Apr 14-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gas & Electric Co

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER M. L. Drake

11 BIRTHPLACE OF FATHER (city or town) N.C.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Naomi Drake
(Address) 3021 Northway.

15 Filed 1930 C. HARRISON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 3/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos ds.

History of Angina

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted unknown
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.

9/5/30, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL Sept 6 1930

20 UNDERTAKER Hughes & Jones ADDRESS 4214 Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60333

CERTIFICATE OF DEATH

101-001 E 60333

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Agnes Hospital (Street) 2572 (Ward)

2-FULL NAME Chas J Shrout

(a) RESIDENCE NO. 918 Brunswick St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Florence I Shrout

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	41	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Metal Worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Francis D Shrout

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ridgeway

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Mrs Florence I Shrout
(Address) 918 Brunswick

1930 C. HAMPSON JONES, M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Right Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas A Brook, M. D.

Sept. 1930 (Address) 3601 3-5

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	9/8 1930
20 UNDERTAKER Harry A Welsh	ADDRESS 401 Edmondson Ave

ec.—1-12-23—M&T—500 Blks.

60334

HEALTH DEPARTMENT—CITY OF BALTIMORE

60334

CERTIFICATE OF DEATH.

159-002

73-31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 118 W. Ostend St. (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edw. Detzel

(a) RESIDENCE NO. 118 W. Ostend ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Oct. 27th 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		10	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: Charles A. Detzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Charles A. Detzel

(Address): 118 W. Ostend St

15 1930 C. HAMPSON JONES, M. D.

A. C. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Sept. 5, 1930, that I last saw him alive on Sept. 5, 1930 and that death occurred, on the date stated above, at 12:15 P m

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

& Mitral Regurgitation

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) 2 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. C. Campbell M. D.

9/6. 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: Sept 6th 1930

20 UNDERTAKER: E. Schlosman & Son

ADDRESS 1039 Hanover

c.—1-30—M. & T.—250 Bks.

E 60335

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60335

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 807 Stephens St. WARD) 7-24

2-FULL NAME Emma Hoover

(a) RESIDENCE NO. 807 Dolphin WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Hardy Hoover

DATE OF BIRTH (month, day, and year) 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer unknown

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Daniel Hollon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary J. Hollon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) 807 Preston St.

Filed Aug 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4/30

17 I HEREBY CERTIFY, That I attended deceased from 8/20/30, 19..., to 9/4/30, 19..., that I last saw alive on 9/4/30, 19..., and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Progressive Cerebral Thrombosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Adler, M. D.

19 (Address) 92 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Aug 7 1930

ADDRESS 1027 Hollins

20 UNDERTAKER John H. Toadvine

c.—2-29-28—L. F. S.—500 Bks.

E 60336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 60336

REGISTERED NO. 19-27

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 1605 W. Fayette ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Salvatore Imbagnglio

(a) RESIDENCE NO. 1605 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

If married, widowed, or divorced (or) WIFE of Salvatore Imbagnglio.

ATE OF BIRTH (month, day, and year) Aug. 17, 1850

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80			18	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Italy.

10 NAME OF FATHER Salvatore Palacardo.

11 BIRTHPLACE OF FATHER (city or town) Italy.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Italy.

(State or country)

Informant Mr. Tony Imbagnglio

(Address) 1605 W. Fayette St.

Filed ..... 1930 ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1930, to Sept. 4, 1930, that I last saw h-- alive on Sept. 4 1930 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerotic Cardio Vascular Renal Disease.

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. A. Tumminello, M. D.

, 19 (Address) 306 N. Greene St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 9/8 1930

20 UNDERTAKER John J. Cowan & Son

ADDRESS 901 Hollins St.

c.—1-30—M. & T.—250 Bks.

E 60337

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60337

CERTIFICATE OF DEATH.

74-601

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 13-59 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Cohen

(a) RESIDENCE NO. 2433 Linden Av St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: yrs. Life time mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Sept 4 1876

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	5	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School 068

(b) General nature of industry, business, or establishment in which employed (or employer) Teacher

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Eleazer Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs M. Blum

(Address) Eutaw Pl.

15 Filed ....., 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-5-30

17 I HEREBY CERTIFY, That I attended deceased from 9/1, 1930, to 9/5, 1930, that I last saw h[illegible] alive on 9/1, 1930, and that death occurred, on the date stated above, at 4.50 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Course

(Signed) Milton B Kirst, M. D.

, 19 (Address) Dorsey Hop

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Crematory

DATE OF BURIAL 9/8/1930

20 UNDERTAKER David Sandhum & Son

ADDRESS 1902 Eutaw Place

E 60338

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60338

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 622 Wyeth St (Ward) 21-29

2-FULL NAME Edward. J. Hall.

(a) RESIDENCE NO. 622 Wyeth St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

If non-resident give city or town and State

If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	9	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Henry Hall.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Wagner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

PARENTS

14 Informant Henry Hall. (Address) 622 Wyeth St

15 Filed 1930 E. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4, 30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1930, to Sept. 4, 1930, that I last saw him alive on Sept 4, 1930 and that death occurred, on the date stated above, at 10:15 pm

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) M G Spillinger M.D.

9/5/30 (Address) 642 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 9/6/30

20 UNDERTAKER Geo Lemlach

ADDRESS 5257 Frederick Rd.

cc.—1-30—M. & T.—250 Bks.

E 60339

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60339

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO. 16-38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6704 Philadelphia Rd. ST. WARD

2-FULL NAME J. Henry Smith

(a) RESIDENCE No. 6704 Philadelphia Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Married~~

If married, widowed, or divorced HUSBAND of (or) WIFE of Belle Smith

DATE OF BIRTH (month, day, and year) June 24, 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore County

(State or country) Maryland

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

Informant Walter T. Smith

(Address) 6704 Philadelphia Road

Filed 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4th, 1930

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to Sept. 4, 1930,

that I last saw him alive on Sept. 4, 1930,

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schmit M. D.

Sept 7 1930 (Address) 701 N. Fairwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Lutheran Cemetery

UNDERTAKER Frederick Lanahan Son

DATE OF BURIAL Sept. 7 1930

ADDRESS 7401 Belair Rd.

c.—1-30—M. & T.—250 Bks

E 60340

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60340

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 21-29 ST. WARD)

2-FULL NAME Ary Davidson

(a) RESIDENCE NO. 415 S. Carrollton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State) Kute Wash. Md.

Length of residence in city or town where death occurred 60 yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William

DATE OF BIRTH (month, day, and year) Feb. 28. 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	6	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER James Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-30-30

17 I HEREBY CERTIFY, That I attended deceased from 8-25-30, 19..... to 8-30-30, 19.....

that I last saw her alive on 8-30-30, 19.....

and that death occurred, on the date stated above, at 9:35 P. m.

The CAUSE OF DEATH* was as follows:

Probable Typhus fever

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No application for autopsy 1-40

What test confirmed diagnosis? Clinical

(Signed) Jas. Stevenson Jr. M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 5 - 1930

ADDRESS

20 UNDERTAKER Baltimore City Health Dept.

Filed SEP 6 1930 1930 C. Hinton Jones M. D. Registrar

ec.—1-30—M. & T.—250 Bks

E 60341

HEALTH DEPARTMENT—CITY OF BALTIMORE E 60341

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Baltimore City Hospitals

ITY OF BALTIMORE: (NO. ST. 4-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Brodo

(a) RESIDENCE NO. 22 N. Frederick St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Willemina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ... 19 ... Registrar

... -1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-30

17 I HEREBY CERTIFY, That I attended deceased from 7-20-26, 19 ..., to 9-1-30, 19 ..., that I last saw him alive on 9-1-30, 19 ..., and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas

(duration) yrs. 2 mos 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. Gbrudek M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: SEP 5 - 1930

20 UNDERTAKER: Commissioner Health — ADDRESS

G. HARRISON JONES, M. D.

ec.—1-30—M. & T.—250 Bks.

Hattie Smith

E 60342 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60342

1-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Provident Hospital

ITY OF BALTIMORE: (No. 514 Division St. 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Smith

(a) RESIDENCE NO. South River - Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) — 1900

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Of

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Robert Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy Boone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alonzo Carroll

(Address) South River

Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1930, to Sept 3, 1930, that I last saw h.. alive on Sept 3, 1930, and that death occurred, on the date stated above, at 8.35 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? South River, Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Carroll, 41 St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem South River

DATE OF BURIAL Sept 6 1930

20 UNDERTAKER Frank Zentz

ADDRESS Pearce

...c.—1-30—M. & T.—250 Bks

E 60343

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60343

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 S Arlington ST. 18-24 WARD)

2-FULL NAME Llorsey L. Llerr

(a) RESIDENCE NO. 15 S Arlington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of Eleanor P. Llerr

DATE OF BIRTH (month, day, and year) Dec. 27-1871

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	8	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Water meter dept.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City

BIRTHPLACE (city or town) Frederick
(State or country) Md.

10 NAME OF FATHER Geo. L. Llerr

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Frances Van Fossen

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant Mrs. Eleanor P. Llerr
(Address) 15 S. Arlington Ave

SEP 6 - 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6-1930

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to Sept 6, 1930, that I last saw him alive on Sept 5, 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) One yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab

(Signed) Henry C. Wolfe, M. D.

9/6, 1930 (Address) 1203 Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila. Pa. DATE OF BURIAL Sept 9 19

UNDERTAKER Wm. J. Tucker Sons ADDRESS N.

ec.—1-30—M. & T.—250 Bks.

240314
E 60344

HEALTH DEPARTMENT—CITY OF BALTIMORE

143 E 60344

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 15-61 WARD)

2-FULL NAME Elsie May Perkins

(a) RESIDENCE NO. 2907 Poplar Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Richard W. Perkins

DATE OF BIRTH (month, day, and year) Feb-23-1892

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	6	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto (State or country) Md.

10 NAME OF FATHER Charles W. Cooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie D. De Von

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) JOHNS HOPKINS HOSPITAL Records

15 Filed FP 6 - 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-4-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930 to Sept-4, 1930, that I last saw her alive on Sept 4, 1930, and that death occurred, on the date stated above, at 10 35 P.m.

The CAUSE OF DEATH* was as follows:

Post-operative shock following operation for tubal pregnancy Rt and chronic appendicitis

(duration) yrs. mos 5½ ds. Hrs. corr

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of Sept 3, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? - Autopsy B.P. etc

(Signed) H. S. Everett, M. D.

9/5, 1930 (Address) The Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmount German U.R. Cem DATE OF BURIAL Sept 8, 1930

20 UNDERTAKER Wm. E. Gickner Sons ADDRESS N. Y. Pa

30—M. & T.—100 B—50L

E 60345

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60345

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 646 W Hoffman St., (WARD) 17-24

2-FULL NAME Edward Drummond

(a) RESIDENCE NO. 646 W. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cornelia Drummond

6 DATE OF BIRTH (month, day, and year): 1878.

7 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: Spencer Drummond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Martha Godfrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

PARENTS

14 Informant: Daisy Jones

(Address): 629 S. Carey St

15 Filed 1930 — HARRISON JONES, M. D. Registrar

C - 1930.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.

(Address) 1186 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Virginia — DATE OF BURIAL: July 6 1930

20 UNDERTAKER: Samuel C Remsley — ADDRESS: 1 E Baltimore

80—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60346 — 74-0 E 60346

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 706 Singer Ave ST., 13 WARD)

2-FULL NAME Mary C Egersdorfer

(a) RESIDENCE NO 706 Singer ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

6a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Charles Egersdorfer

6 DATE OF BIRTH (month, day, and year): Dec 25th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jacob Reil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Schdilger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas Egersdorfer

(Address): 706 Singer Ave

15 Filed 9-1-1930 H. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) ..... yrs. ..... mos 2 hrs

CONTRIBUTORY (Secondary) Shock (duration) ..... yrs. ..... mos. 2 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Pt History

(Signed) G C Slater Coroner, M. D.

, 19 (Address) 143 W Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's (Harlsdem) Cemetery

DATE OF BURIAL: 9/8/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul st

Rec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60347

E 60347

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 616 N. Eden St., 87-42 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Donovan

(a) RESIDENCE NO. 2721 Kildaire Drive St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Dennis Donovan

7 DATE OF BIRTH (month, day, and year): Dec 9-1868

AGE: Years 61 | Months 8 | Days 21 | If LESS than 1 day, hrs or min. 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

10 NAME OF FATHER: Laurence Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Gerr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ...

PARENTS

14 Informant: Dennis Donovan

(Address): 616 N Eden ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5" 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/5 1930, to 9/5 1930,

that I last saw h~~e~~ alive on 9/5 1930,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 5 mos ... ds.

CONTRIBUTORY (Secondary) Due to cardiac dilatation

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 Wilkens ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Sept 8 1930

UNDERTAKER: J. M. Donovan

ADDRESS: 811 N Wolfe

cc—1-30—M. & T.—250 Bks.

E 60348 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 129 E 60348

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME Richard Sonnesburg

(a) RESIDENCE NO. Preston + Valley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 3rd 1844

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	7	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) .....
(State or country) Germany

10 NAME OF FATHER August Sonnesburg

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Mathilda Herman

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

Informant Little Sisters of the Poor
(Address) Preston + Valley St.

Filed 9-7-1930 H. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1930, to Sept 6, 1930, that I last saw h[illegible] alive on Sept 5, 1930, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ~~~

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Asst. R. Gerhardt M. D.

9/6, 1930 (Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Sept 8 1930

20 UNDERTAKER Rita Friedfeld — ADDRESS 914 Druid Pk One

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60349 E 60349

CERTIFICATE OF DEATH

REGISTERED NO. 17

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. Harry A. Wilson

(a) RESIDENCE NO. Greenway Apts. ST.

WARD

(If non-resident give city or town and State)

(Usual place of abode)

ngth of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of (or WIFE of) Mrs. H. A. Wilson

6 DATE OF BIRTH (month, day, and year) April 24, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Harry A. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md.

12 MAIDEN NAME OF MOTHER Elizabeth (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant Hospital Records

(Address)

Filed 7-1930 19 C. PAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1930, to Sept. 6, 1930, that I last saw h[illegible] alive on Sept. 6, 1930 and that death occurred, on the date stated above, at 2:25 9 m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

Perforated Appendicitis

(Gangrene)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (secondary) Myocardial failure

(duration) yrs mos. 21 ds.

18 Where did disease contracted if not at place of death? Greenway Apt. 19/5/30

Did operation precede death? yes, Date of

Was there an autopsy? No.

What was confirmed diagnosis? Clinical findings.

(Signed) Robert Cockwell M. D.

(Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemy	Sept 8, 1930
20 UNDERTAKER John A. Mitchell & Son	ADDRESS 1222 Eutaw Pl

sec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60350 16-002 E 60350

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1215 N Stricker St. WARD)

2—FULL NAME John Montague Jr

(a) RESIDENCE NO. 1215 N Stricker St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Apr 3rd 30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	6		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER John Montague Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louise Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant

(Address) 1215 N Stricker St

Filed 7-1930 C. HAMILTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6-30

17 I HEREBY CERTIFY, That I attended deceased from 9-5, 1930, to 9-6-, 1930 that I last saw h[illegible]alive on 9-6-, 1930 and that death occurred, on the date stated above, at 10:10 PM

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 6 da. ds.

CONTRIBUTORY (Secondary) Gastro Intestinal disturbance due to Milk (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1215 Stricker St

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M Boyle, M. D.

, 19 (Address) 1512 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Sept 8 1930

UNDERTAKER Thomas E Wright ADDRESS 700 N Carrollton Ave

Sec.—1-30—M. & T.—250 Blks

E 60351

E 60351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 Augusta Ave ST., 20-21 WARD)

2-FULL NAME John Napfel

(a) RESIDENCE NO. 315 Augusta Ave ST., 20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of or) WIFE of Late Mary Napfel

DATE OF BIRTH (month, day, and year) Nov. 18th 1848

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	9	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cigar

(b) General nature of industry, business, or establishment in which employed (or employer) Maker

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John Napfel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Geo. M. Napfel (Son)

(Address) 315 Augusta Ave

Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4/30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Sept 4, 1930, that I last saw h— alive on Sept 4, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chole Cystitis

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Dyspepsia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. Wahl, M. D.

Sept. 5, 19 30 (Address) 411 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Sept 8 1930

20 UNDERTAKER D. Lilly & Sons

ADDRESS 403 S Wolfe St

CHARLES JONES, M. D.

Registrar

7-1930

ec.—1-30—M. & T.—250 Bks

E 60352

E 60352

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

CERTIFICATE OF DEATH.

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3411 Toone ST., (or WARD) No-37

2-FULL NAME Joseph Green Daffin

(a) RESIDENCE NO. 3411 Toone ST., 26 WARD ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced (HUSBAND) of or) WIFE of Lena E. Daffin

DATE OF BIRTH (month, day, and year) Feb 8th 1842

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	88	6	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Charles D. Daffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary E. Dowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Lena E. Daffin

(Address) 3411 Toone St

Filed 1930 19 ... H. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5th/30

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to Sept 5, 1930,

that I last saw him alive on Sept 4, 1930,

and that death occurred, on the date stated above, at 2 10/a. m.

The CAUSE OF DEATH* was as follows:

coma following cerebral hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchitis - Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Sept [illegible], 19[illegible] (Address) 1014 S. Wood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Sept 8th 1930

20 UNDERTAKER Lilly & Zeiler Inc. — ADDRESS 403 S. Wolfe St

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60353 — 60-001 ✓ E 60353

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 2944 Harford Rd ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frieda Schultz

(a) RESIDENCE NO. 2944 Harford Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
emale	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 3, 1878

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	1	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER John P. Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mr Louis H. Schultz

(Address) 2944 Harford Rd

Filed ... 19 ... By ... JONES, H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1930

17 I HEREBY CERTIFY, That I attended deceased from February 19, 1929, to Sept 5, 1930, that I last saw h[illegible] alive on Sept 5 1930 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory tests

(Signed) Helen G Singwald, M. D.

9/6, 1930 (Address) 1613 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Immanuel Cem.

DATE OF BURIAL Sep. 8, 1930

20 UNDERTAKER L. H. Louis Heumann

ADDRESS 32 S. Bradford

6-9-19—H. P. Co.—1000 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60354

122-E 60354

CERTIFICATE OF DEATH.

REGISTERED NO. 95-74

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3301 Old Annapolis Road ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick L. Sanders

(a) RESIDENCE. No. 3301 Old Annapolis Road ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Mary E. Sanders

6 DATE OF BIRTH (month, day, and year): Mch 2nd 1870

7 AGE: Years 60 Months 6 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: George Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mary E. Sanders 3301 Old Annapolis road

15 Filed: 8-1930 C. HAMPTON JONES, M. D. Registrar

Fee: Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/6/30

17 I HEREBY CERTIFY, That I attended deceased from 9/5/30, 19 , to 9/6/30, 19 , that I last saw h[illegible] alive on 9/5/30 19 , and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis

Acute Influenza

Chronic Duodenal Ulcer

Duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John F. Alexander M. D.

9/6/1930 (Address) 1 W. Mt. Vernon Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Sept 9th 1930

20 UNDERTAKER: C. Schlosman & Son

ADDRESS 1039 Hanover St

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60355

CERTIFICATE OF DEATH.

E 60355

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH The Alms House (WARD) 20

CITY OF BALTIMORE: (NO.) Eutaw Place & Laurel St

2-FULL NAME Mrs Mary Rogers Summers

(a) RESIDENCE NO. The Alms House ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, (Widowed), or Divorced, (write the word)
F	W	

If married, widowed, or divorced HUSBAND of (or) WIFE of Chas G. Summers, Dec

DATE OF BIRTH (month, day, and year) 11/1/1847

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	8	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore City Md

10 NAME OF FATHER David E. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Susan Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Chas Summers Jr

(Address) 104 W. Monument St

Filed 9/7 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7/1930

17 I HEREBY CERTIFY, That I attended deceased from 8/31/30, 19.. to 9/7/30, 19..

that I last saw h.. alive on 9/6/30, 19.. and that death occurred, on the date stated above, at 1.20 p.m. ST

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Jno A Thompson, M. D.

9/7/30 (Address) 800 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge

DATE OF BURIAL Sept 10 1930

20 UNDERTAKER Leary & Perkins Inc

ADDRESS McCulloh & Eutaw Sts

...—1-30—M. & T.—250 Bks.

E 60356 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60356

48

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1220 Bonaparte ave ST. 9-47 WARD)

2-FULL NAME Julian Graham Wrightson

(a) RESIDENCE NO. 1220 Bonaparte ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie C. Wrightson

DATE OF BIRTH (month, day, and year) 7/12/1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	1	25	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bond Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Bankers & Brokers
(c) Name of employer J. H. Wilson Jr & Co

BIRTHPLACE (city or town) Easton
(State or country) Maryland

10 NAME OF FATHER Hugh S. Wrightson

11 BIRTHPLACE OF FATHER (city or town) Talbot County Md
(State or country)

12 MAIDEN NAME OF MOTHER Juliana Dodson

13 BIRTHPLACE OF MOTHER (city or town) St Michaels
(State or country) Maryland

Informant Annie Corinne Wrightson
(Address) 1220 Bonaparte ave

Filed 8-1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1930

17 I HEREBY CERTIFY, That I attended deceased from
April, 1930, to Sept 6, 1930,
that I last saw h[illegible] alive on Sept 6, 1930,
and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:
Cancer of the face

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY —
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) Geo. L. Simmons, M. D.
9/7, 1930 (Address) 9850 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem.
DATE OF BURIAL Sept 9th 1930

20 UNDERTAKER Henry A. Jenkins Sons & Co
ADDRESS McCulloh & Eutaw Sts.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60357

E 60357
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced Dead at
City of Baltimore: (No. Balto City Hospital St. 16-37 (Ward)

2-FULL NAME Louis Pozanik

(a) RESIDENCE NO. 3800 Eastern ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Belle Pozanik

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) Self 0 3½
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER David Pozanik

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Belle Pozanik
(Address) 3800 Eastern ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
Sudden
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Diabetis Mellitus
(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) James M Fenton M. D.
19 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel
DATE OF BURIAL 9-8- 1930

20 UNDERTAKER Jack Lewis, 1434 E Balto st
ADDRESS

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60358

E 60358

CERTIFICATE OF DEATH.

111-001

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St Joseph's Hosp 41-44 WARD)

2-FULL NAME Charles Starks

(a) RESIDENCE NO. 4711 Carlton St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Catherine Sapp

DATE OF BIRTH (month, day, and year) — — 1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer.

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Henry Starks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Priscilla Gregg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Mrs C. Hampton Jones

(Address) 4711 Carlton Ave

Filed 1930. 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6-1930.

17 I HEREBY CERTIFY, That I attended deceased from 8-31, 1930, to 9-6, 1930, that I last saw h[illegible] alive on 9-6, 1930, and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy.

(Signed) M B Hendrix M. D.

19, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 9/8 1930

ADDRESS 31 Wright St.

UNDERTAKER [illegible]

ADDRESS [illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60359

CERTIFICATE OF DEATH

90 E 60359

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hospital St., 7-12 Ward)

2-FULL NAME William H. Davis

(a) RESIDENCE NO. 2512 Eager Place St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary J Davis

6 DATE OF BIRTH (month, day, and year) June 2 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Wm H Davis Sr

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Nora Betz

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant Mary J. Davis
(Address) 2512 Eager Place

15 Filed SEP 8 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Decompensation

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No Clinical

What test confirmed diagnosis? .....

(Signed) James H Benton, M. D.

9 6. 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Sept 8 1930

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 60360

E 60360

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St., 1-1 Ward)

2-FULL NAME Conrad Finger

(a) RESIDENCE NO. 734 S Linwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie E Finger

6 DATE OF BIRTH (month, day, and year) Mar. 5 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Trackman
(b) General nature of industry, business, or establishment in which employed (or employer) Balto City
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Conrad Finger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Annie E Finger
(Address) 734 S Linwood Ave

15 Filed 8-1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fracture of (Side) Skull; fall on street car track accident
(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Observation
(Signed) Hampson Jones, M. D.
Sept. 5 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL Sept 8 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager

60361

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 E 60361

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Mount St. St., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys M. Tuerke

(a) RESIDENCE NO. 120 S. Mount St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 12 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) April 24.1902

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	4	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Frederick E. Tuerke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Alice May Burrows

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. John F. Schindler

(Address) 120 S. Mount St.

15 Filed 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1930 to Sept. 6, 1930

that I last saw her alive on Sept 6, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Kuslukian, M. D.

9/8 1930 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Sept. 10 1930

ADDRESS

20 UNDERTAKER George W. Little 2700 Edmondson Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60362 — CERTIFICATE OF DEATH — E 60362

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) U. S. Marine Hospital St., 12-51 (Ward)

2-FULL NAME Jose M. Perieza.

(a) RESIDENCE NO. 98 Pioneer St., Brooklyn St. N. Y. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24, 1893

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
37	5	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer SS Anniston City

9 BIRTHPLACE (city or town)
(State or country) New York

PARENTS

10 NAME OF FATHER Anthony Perieza

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Brazil

12 MAIDEN NAME OF MOTHER
Mary -------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Brazil

14 Informant U. S. Marine Hospital Record
(Address) Baltimore, Md.

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
Accidental Death by Gunshot
Fatal wound Skull Undetermined

(duration) ... yrs. ... mos. ... ds.?

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9-8 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden — DATE OF BURIAL Sept. 8, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc. — ADDRESS 125 E. North Ave.

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

60363

CERTIFICATE OF DEATH.

90 E 60363

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital · St. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Idzig

(a) RESIDENCE NO. 1908 Fleet St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) [illegible]

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84?				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Anton Primel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

Informant (Address) Hospital Records.

Filed SEP 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6-30

17 I HEREBY CERTIFY, That I attended deceased from 7-31- 1930 to 9-6 1930, that I last saw h[illegible] alive on 9-6-30, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic
Arteriosclerosis

(duration) yrs. 2 mos 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Idzig Jr, M. D.

, 19 (Address) City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery — DATE OF BURIAL Sept 9 1930

20 UNDERTAKER George A. Weber — ADDRESS 705 E Lanvale

No.—2-29-28—L. F. S.—500 Bks.

E 60364 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 60364

Brooklyn

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 532 Annabel Ave 25-75 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace E. WHITE. Conway

(a) RESIDENCE NO. 532 Annabel Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene F Conway

DATE OF BIRTH (month, day, and year) Aug 19 1910

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20		16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Barney A White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Emma A Travers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Mrs Emma A White

(Address) 532 Annabel Ave

Filed 1930 C. Hayden Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1930, to Sept 5, 1930, that I last saw h alive on Sept 4, 1930, and that death occurred, on the date stated above, at 2 20 A m. D.S.T.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Two months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke, M. D.

Sept 5, 1930 (Address) 361 Third St, Brooklyn Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Sept 8 1930

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 60365

60365

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver St. 1359 WARD)

2-FULL NAME Augusta V. Marks

(a) RESIDENCE NO. 2415 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Frank Marks

DATE OF BIRTH (month, day, and year) 1895

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Petersburg Va.

10 NAME OF FATHER John W. Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mollie E. Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Frank Marks

(Address) 2415 Druid Hill Ave

Filed 8-1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-5-30.

17 I HEREBY CERTIFY, That I attended deceased from 9-2, 1930, to 9-5, 1930.

that I last saw h[illegible] alive on 9-5-, 1930.

and that death occurred, on the date stated above, at 4:28 P m.

The CAUSE OF DEATH* was as follows:

Multiple uterine fibroids

Nephritis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Auricular fibrillation + Syphilis. (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 9-3-30.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical, Operation + Lab.

(Signed) [illegible], M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Sept 6 19 30

20 UNDERTAKER [illegible]

ADDRESS [illegible]

30—M. & T.—100 B—50L

E 60366

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

160 E 60366

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 685 Josephine ST., 4-25 WARD)

2-FULL NAME Mary Jackson

(a) RESIDENCE NO 685 Josephine ST., _____ WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nov 8 - 1929

7 DATE OF BIRTH (month, day, and year) Nov 8, 1929

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robt Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cecelia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lurline Jackson

(Address) 685 Josephine St

15 Filed 8-1930 192 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) _____ yrs. _____ mos _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Eugene Feller, M. D. Coroner

9/8, 1930 (Address) [illegible] Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn

DATE OF BURIAL 9/8/30 19

ADDRESS [illegible] W Baltimore

20 UNDERTAKER Samuel Hemsley

C.—1-30—M. & T.—250 Bks.

E 60367 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60367

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 17-24 WARD)

2-FULL NAME Lawrence Jenkins

(a) RESIDENCE NO. 1146 Shields alley WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Fannie ?

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48		—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) Bakery

(c) Name of employer ?

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Joseph Jenkins

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Mohamet ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

Informant (Address) Parents Res. Baltimore City Hospitals

Filed SEP 8 - 1930 HARRY COLLINS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-30

17 I HEREBY CERTIFY, That I attended deceased from 4-25-, 1930, to 9-3-, 1930,

that I last saw him alive on 9-3-, 1930,

and that death occurred, on the date stated above, at 4.00 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 2 hrs.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 2-14-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings

(Signed) Fred M. Oncken M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL Sept 8, 1930

ADDRESS 3221 Schroeder St.

20 UNDERTAKER Mrs Kate R. Williams

ec.—1-12-23—M&T—500 Bks.

60368

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60368

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1416 W. Lanvale St. 16-27 (WARD)

2-FULL NAME Levi Woolford

(a) RESIDENCE NO. 1416 W. Lanvale ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

If married, widowed, or divorced: ~~WIFE~~ HUSBAND of Emma Woolford

DATE OF BIRTH (month, day, and year) 1880

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Minister

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

BIRTHPLACE (city or town) (State or country): Trappe, Md.

10 NAME OF FATHER: John Woolford.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Trappe, Md.

12 MAIDEN NAME OF MOTHER: Mary Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Trappe, md

14 Informant: Mrs Elizabeth Snavely (Address) 1021 Linden ave

15 Filed 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/25, 1930, to 9/5, 1930, that I last saw h~~im~~ alive on 9/5, 1930, and that death occurred, on the date stated above, at 11-45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Probably 1 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. N. Pigott, M. D.

9/8, 1930 (Address) 1536 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trappe, Talbot Co, Md.

DATE OF BURIAL: Sept 9, 1930

20 UNDERTAKER: Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

Registrar

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60369

E 60369

CERTIFICATE OF DEATH

182

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found in the Canton 2-4 Ward)

City of Baltimore: (No. Harbor 77

2-FULL NAME Adam Dzwonkowski

(a) RESIDENCE NO. 212 S Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Dzwonkowski

6 DATE OF BIRTH (month, day, and year) June 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Casby Dzwonkowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Mary Dzwonkowski
(Address) 212 S Wolfe St

15 Filed Sept 5 1930 C. HARVEY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

(duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Why body found in water?

(Signed) James M Kenton M. D.

Sept 5 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Sept 9 1930

DATE OF BURIAL

20 UNDERTAKER F. P. Wozniak

ADDRESS 1900 Eastern Ave

30—M. & T.—100 B—50L

60370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

177 ✓ E 60370

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hopkins Hospital ST. 10-14 (WARD)

2-FULL NAME Edward Amos

(a) RESIDENCE NO 825 McKim ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	married

6a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Eva Amos

6 DATE OF BIRTH (month, day, and year) Jan 4/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	9	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer Security Storage Co

9 BIRTHPLACE (city or town) (State or country) Balto., Co., Md.

PARENTS

10 NAME OF FATHER John Amos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Nears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eva Amos (Address) 825 McKim St

15 Filed ..... 19.. Registered ..... 19..

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 4/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Phenol Poisoning- Swalloed Lysol by mistake, thinking it whisky.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto Co., Md

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy & Analysis

(Signed) /s/ H. Colton, M. D. Coroner

9/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Sept 8, 1930

20 UNDERTAKER C. Mos. R. G. Elliott

ADDRESS 1725 Eastlander

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60371

CERTIFICATE OF DEATH

166 E 60371

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St., [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arlen Simpson

(a) RESIDENCE NO. McKeys Port Pa St., Ward

(Usual place of abode) Unknown

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23 1910

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	20	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) McKeysport Pa.

PARENTS

10 NAME OF FATHER John Gilmore

11 BIRTHPLACE OF FATHER (city or town)
(State or country) McKeysport Pa

12 MAIDEN NAME OF MOTHER Mary Frye

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) Mercy Hospital

15 Filed 1930. C. PEARSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hydrocyanic Poisoning taken while under influence of alcohol. Suicide Probable
6 days (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Nephritis (a.r.i.)
Hendrix (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Simmons St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. T. Peters, M. D.

Sept 8 1930 (Address) 1439 Bonaday

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monumental Cem. McKeys Port Pa. DATE OF BURIAL Sept 10/30 19

20 UNDERTAKER Chas. L. Stevens ADDRESS 1507 E Fort Ave

—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 E 60372

E 60372

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 E Fayette ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mildred Slechta

(a) RESIDENCE NO. 2222 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 7 30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or 15 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Frank Slechta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mildred Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Frank J. Slechta

(Address) 2222 E Fayette st

Filed SEP 8 1930 JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1930, to Sept 7, 1930, that I last saw h[illegible] alive on " " , 1930 and that death occurred, on the date stated above, at 11-59 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth of seven months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) A. C. Hearn, M. D.

9/8, 1930 (Address) 1901 Fairmount Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Sept 8 1930

20 UNDERTAKER Vint Funeral Home

ADDRESS 1006 Eastern Ave

C.—1-30—M. & T.—250 Bks.

E 60373 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 60373

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Kirkleigh Villa ST. 27-49 (WARD)

2-FULL NAME Minna Lowenberg

(a) RESIDENCE NO. 4301 Roland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced
HUSBAND of
or) WIFE of Max Lowenberg 1839 1917

DATE OF BIRTH (month, day, and year) Dec 30 1839

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	9	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Nordisia Vallentarfs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie Samuels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. S. Eisenman
(Address) 3600 Liberty Heights Ave

Filed Sept 8, 1930 C. Finley JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7. 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1930, to Sept 7, 1930, that I last saw her alive on Sept 7, 1930, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

terminal (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lentz, M. D.

Sept 8, 1930 (Address) Temple Garden apts

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Cemetery

DATE OF BURIAL Sept 9 1930

ADDRESS

UNDERTAKER Sauter Funeral Co

ADDRESS 1402 Eutaw Pl

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60374 — 90 E 60374

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1642 Caddon St. (Ward) 25-77

(If death occurred in a hospital or institution give its NAME instead of street and number.)

2-FULL NAME Mary Sexton

(a) Residence No. 1642 Caddon st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed or Divorced (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thomas Sexton Sr.

6-DATE OF BIRTH (month, day and year) Feb 10-1855

7-AGE 75 yrs. 6 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) England

PARENTS

10-NAME OF FATHER John Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) England

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14 (Informant) Thomas J. Sexton

(Address) 1642 Caddon St

15- Filed 1930 CLAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 5/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1929 to Sept 5 1930

that I last saw her alive on Sept 4 1930

and that death occurred, on the date stated above, at 5 30 P. M.

The CAUSE OF DEATH was as follows:

Arthritis Deformans

Chronic Myocarditis

Long Duration

CONTRIBUTORY (Secondary) Chron Myocarditis (Duration) Long Standing yrs. mos.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Hodes M. D.

Sept 6 1930 (Address) 4700 Pennington

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery DATE OF BURIAL Sept 9 1930

20-UNDERTAKER Robt J Turner ADDRESS 1642 E. Broadway

Spec.—1-10-21—M&T—1500 Bks.

Glenn ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60375

CERTIFICATE OF DEATH.

90 E 60375

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (NO. 18-29 ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Martin Glenn

(a) RESIDENCE NO. 707 Lemmon St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): ~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sate Rosa (nee, Hellen)

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE: Years: about 47 Months: Days: If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Dennis Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary McKew

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Margaret Sewell

(Address) 2203 Eutaw Place

Filed 9-8-1930 HARWOOD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-5- 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-7, 1930 to 9-5, 1930, that I last saw h/her alive on 9-5, 1930, and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Arteriosclerotic)

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hjalmar S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 9/9/30

20 UNDERTAKER: Harry H Weitzke — ADDRESS: 460 Edmondson

c.—1-30—M. & T.—250 Bks.

E 60376 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60376

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 820 Rutland Ave ST., 12 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willy G. Jones

(a) RESIDENCE NO. 558 24th N.E. ST., Washington D.C. WARD Washington D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Chas. H. Jones

DATE OF BIRTH (month, day, and year) 1885

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 010
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Richmond Va.

10 NAME OF FATHER James T. McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Chas. H. Jones (Address) 558 24th St N.E. Wash D.C.

15 Filed Sept 8 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6.

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 19 30, to Sept 6, 19 30,
that I last saw h... alive on Sept 6, 19 30, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis
Heart Knew.
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Carbuncle Failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) J. Marshall Wolfe M. D.
Sept 8, 1930 (Address) 1119 N. Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.
DATE OF BURIAL Sept 8 1930

20 UNDERTAKER Mrs. R. G Elliott
ADDRESS 1725 Ashland Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60377

CERTIFICATE OF DEATH.

129 E 60377

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2912 Reed St. St., 9-46 Ward

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur C. Cumbacker

(a) RESIDENCE NO. 2912 Reed St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Margaret C Cumbacker

6 DATE OF BIRTH (month, day, and year): Sept 8 - 1877

7 AGE — Years: 52 Months: 11 Days: 28 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Carroll Co.

(State or country)

PARENTS

10 NAME OF FATHER: Jesse Cumbacker

11 BIRTHPLACE OF FATHER (city or town): Carroll Co.

(State or country)

12 MAIDEN NAME OF MOTHER: Cecilia Otto

13 BIRTHPLACE OF MOTHER (city or town): Carroll Co.

(State or country)

14 Informant: Mrs. Margaret C Cumbacker

(Address) 2912 Reed St

Filed ..... 19 ..... Registrar

8 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 6/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure- Hypertension

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (secondary) Chr Nephritis

(duration) (2) yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

9/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the state .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

Date of Burial Sep 9 1930

20 UNDERTAKER: A.S. Marshall

ADDRESS 539 Dell Rd

Jingstron ✓ ✓

E 60378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60378

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp ST. 16-bX (WARD)

2-FULL NAME Samuel Jingston

(a) RESIDENCE NO. Solomon's Island Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Reva Jingstron

7 DATE OF BIRTH (month, day, and year) July 5-1881

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49 yrs	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Beth Copper Mfg Co

9 BIRTHPLACE (city or town) (State or country) Solomons, Md

PARENTS

10 NAME OF FATHER Samuel Jingstron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Julia Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Reva Jingstron (Address) Solomons Md

15 Filed 8-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/8 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/20, 1930, to 9/8, 1930, that I last saw h alive on 7/8, 1930, and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H Ashman, M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Solomons Md

DATE OF BURIAL 9/8 1930

ADDRESS 1211 St-Paul St

20 UNDERTAKER Wellans Co

6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90 E 60379

E 60379

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1736 N. Dallas ST. 8-17 WARD

2-FULL NAME Christy Williams

(a) RESIDENCE NO. 1736 N. Dallas ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Augs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1890

7 AGE: Years 40 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House Worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Mamie Williams 1736 Dallas St

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Sept 6, 1930, that I last saw her alive on Sept 6, 1930, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:
Cardiac Vesicular Edema

(duration) — yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) (a) Uremia (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles T. Forsythe M. D.

Sept 8 1930 (Address) 712 S. Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Va.

DATE OF BURIAL: 9-9-1930

ADDRESS 716 Oakland

20 UNDERTAKER: Reed Carlson

SEP 8 - 1930 C. HAMILTON JONES, M. D.

c.—1-30—M. & T.—250 Bks.

E 60380

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 60380

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1712 Brooks 2nd ST. 16-22 WARD)

2-FULL NAME King Hawkins

(a) RESIDENCE NO. 1712 Brooks 2nd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 1891

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	—	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Henry Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Emma Giles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Daisy Hawkins

(Address) 1712 Brooks 2nd

15 Filed SEP 3 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Sept 7, 1930,

that I last saw him alive on Sept 7, 1930,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Long, M. D.

, 19 (Address) 1712 Brooks 2nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littleton N. C.

DATE OF BURIAL 9-7-1930

20 UNDERTAKER Dave Ervin

ADDRESS 916 Davie

30—M. & T.—100 B—50L

E 60381

E 60381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 414 Middle St. (WARD) 17-21

2-FULL NAME Mary Thurza Green

(a) RESIDENCE NO. 414 Middle St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Single

6b DATE OF BIRTH (month, day, and year): Oct 1908

7 AGE: Years 22; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Dailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Evelyn Green

(Address): 2536 Eutaw Pl

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary): Error of diet

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Bruce Brown, M. D. Coroner

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northern Cemetery

DATE OF BURIAL: 7-9 1930

20 UNDERTAKER: Arnold Taylor

ADDRESS: Pa ave.

c.—1-30—M. & T.—250 Bks.

E 60382 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60382

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH Aged Women's Home
CITY OF BALTIMORE: (No. 1404 N Lexington ST. 14-7 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Sara M Todd

(a) RESIDENCE NO. 1404 N Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 28 1847

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	9	14	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Cattonage Co
(State or country)

10 NAME OF FATHER Joshua F Todd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Catherine Talbott

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Co Md

Informant Mrs Martha E Baker
(Address) 1404 N Lexington St

HARRISON JONES, M.D.
Registrar

1930 ....., 19 .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to Sept 5, 1930.
that I last saw her alive on Sept 5, 1930.
and that death occurred, on the date stated above, at 3:50 A. m.
The CAUSE OF DEATH* was as follows: Carcinoma of breast

(duration) 3 yrs. mos ds

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Edwin C Jarrett M. D.
, 19 (Address) 1115 St Paul St., City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem
Barrett & Delight Balto

DATE OF BURIAL Sept 9 1930
ADDRESS 1532 Hollins St

20 UNDERTAKER George L Smith

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60383

CERTIFICATE OF DEATH.

90 ✓ E 60383

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave. Ward 27)

2-FULL NAME Emma Baker

(a) RESIDENCE Home for the Aged M.E. Ch. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: none.

6 DATE OF BIRTH (month, day, and year): Sept. 5, 1854

7 AGE: Years 76 | Months 0 | Days 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Baker.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Jane Fitzgerald.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto. Md.

14 Informant: M. B. Trout.

(Address): 400 N. Fulton Ave

15 Filed: 19 30 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 7 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1930, to Sept 7, 1930, that I last saw her alive on Sept 6, 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted ✓

If not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Geo. E. Shannon, M. D.

(Address) 700 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery Date of Burial: Sept 9 1930

20 UNDERTAKER: George J. Smith ADDRESS: 1532 Hollins

c.—1-30—M. & T.—250 Bks.

60384 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Aged Women Home

CITY OF BALTIMORE: (No. 1404 W Lexington ST., 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Melanie Long

(a) RESIDENCE No. 1404 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 7 1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs Martha E Baker

(Address) 1404 W Lexington

Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927 to Sept. 8, 1930

that I last saw h.. alive on Sept. 5, 1930

and that death occurred, on the date stated above, at 7:45 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B Jones M.D.

, 19 (Address) 1110 St Paul St, City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 10 1930
20 UNDERTAKER George Smith	ADDRESS 1532 Hoffman

c—1-30—M. & T.—250 Bks.

E 60385 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60385

CERTIFICATE OF DEATH.

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1700 N Calvert St. 12-19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ross Campbell Holliday

(a) RESIDENCE NO. 1707 N. Calvert St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Elder

DATE OF BIRTH (month, day, and year) Dec. 11, 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales agent 009

(b) General nature of industry, business, or establishment in which employed (or employer) Mfrs. agent

(c) Name of employer Independent

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Daniel Holliday

11 BIRTHPLACE OF FATHER (city or town) Winchester (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie Rutherford

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Maryland

Informant Margaret E. Holliday

(Address) 1700 N. Calvert St.

Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1930, to Sept. 7, 1930, that I last saw him alive on Sept. 7, 1930, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Angina-Pectoris

(duration) 2 yrs. + mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. F. Robinson, M. D.

9/8, 1930 (Address) Private Office Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmount Cem. DATE OF BURIAL Sept 10 1930

UNDERTAKER Henry Wyndham & Co. ADDRESS 6 Calvert St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60386

E 60386

CERTIFICATE OF DEATH.

REGISTERED NO. 111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3405 Keswick Road (ST.) 13-52. (WARD)

2-FULL NAME Lloyd E. Stevens

(a) RESIDENCE NO. 3405 Keswick Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertie E. Stevens

6 DATE OF BIRTH (month, day, and year): Aug 18/1898

7 AGE: Years 32 | Months 0 | Days 20/9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman- Smoke House

(b) General nature of industry, business, or establishment in which employed (or employer): J. W. Crooks 08

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Essex Co., Va.

PARENTS

10 NAME OF FATHER: Wood Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Anna Courthorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Bertie Stevens, 3405 Keswick Road

15 Registrar: C. HAMPSON JONES, M. D.

8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep 7/30 19

17 I HEREBY CERTIFY, That I attended deceased from September 6 19 30 to September 7/30 19

that I last saw him alive on September 6/30 19

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of over

Was there an autopsy? no

What test confirmed diagnosis? History given by Dr. Dehoff E. Chas. S

(Signed) [signature] M. D.

9/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Essex Co Virginia

DATE OF BURIAL: Sept 10 1930

20 UNDERTAKER: [signature]

ADDRESS: 305 Chestnut ave

c.—1-30—M. & T.—250 Bks.

E 60387 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60387

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) (Ward) 27-4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Eads.

(a) RESIDENCE NO. 4434 Wrenwood (St.) ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23rd 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11 yrs.	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

10 NAME OF FATHER John M. Eads

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Rose Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Mrs Rose Eads

(Address) 4434 Wrenwood Ave

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-6-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 , 1930 , to Sept 6- , 1930 .

that I last saw h him alive on Sept 6- , 1930 ,

and that death occurred, on the date stated above, at 7.25 P. m. E.S.T.

The CAUSE OF DEATH was as follows:

Ruptured appendix-
Peritonitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Leucemia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 9-5-30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Robert Eads, M.D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 9/9/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

30—M. & T.—100 B—60L

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 E 60388

E 60388

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Boyd St. 70-64 WARD)

2-FULL NAME Dorothy R. Dieguez

(a) RESIDENCE NO. 2232 Boyd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28-1929

7 AGE — Years: — Months: 8 — Days: 9 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Carl S. Dieguez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Beyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Carl S. Dieguez

(Address) 2232 Boyd

15 ..... 1930 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Natural Causes

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Brooke Coroner M. D.

Sept. 7, 1930 (Address) 1 Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Sept 9 1930

20 UNDERTAKER: Harry A. White

ADDRESS: 4101 Edmondson

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60389

E 60389

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 2142 N. Lexington ST. WARD

2-FULL NAME Mary Wagner

(a) RESIDENCE NO. 2142 N. Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Wagner

6 DATE OF BIRTH (month, day, and year): Mar 27 1850

7 AGE: Years 80; Months 5; Days 10

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry Pessler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George A. Wagner

(Address) 2142 N. Lexington St

15 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1930 to Sept 7 1930.

that I last saw him alive on Sept 6 1930.

and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Senile Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Uremia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Kaufmann M. D.

(Address) 1 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery

DATE OF BURIAL: 9/9 1930

20 UNDERTAKER: Wm. Cook.

ADDRESS: 1212 Eutaw Pl

Rec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60390 100-01 ✓ E 60390

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 West Lombard ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Morgan Smith

(a) RESIDENCE NO. 1010 West Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13 1923

AGE	Years	Months	Days 24	If LESS than 1 day, hrs. or min.
	8	I	23	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Charles L Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Car olinia

12 MAIDEN NAME OF MOTHER Grace Morgan

13 BIRTHPLACE OF MOTHER (city or town) Charles Co (State or country) Mar yland

Informant Mrs Grace Smith

(Address) 1010 W. Lombard St.

Filed ... 19 ... Registrar

No. 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 1930 to Sept 7 1930

that I last saw h alive on Sept 7 1930

and that death occurred, on the date stated above, at 5. 15 A.m.

The CAUSE OF DEATH* was as follows:

Bronch. pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical findings

(Signed) J. Hind Mutch M. D.

, 19 (Address) 2147 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept. 9 19 30

20 UNDERTAKER Joseph B. Cook

ADDRESS 803 W. Baltimore St.

ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60391

CERTIFICATE OF DEATH

90 E 60391

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 1210 West Fayette ST. 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME EDWARD E. KENT
1210 West Fayette

(a) RESIDENCE NO. ST., WARD
(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of (or) WIFE of MARY E. KENT

DATE OF BIRTH (month, day and year) January, 26 1861

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R.

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Edwrad E. Kent.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Alice Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) VA

Informant Mrs. John S. Webb

(Address) 1210 West Fayette St

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) September, 7" 1930

17 I HEREBY CERTIFY, That I attended deceased from March 20 1930, to Sept 7 1930, that I last saw h alive on Sept 7 1930 and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Sept 8/30 (Signed) T. Norwood, M. D.

, 19 (Address) 939 West Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept. 10" 1930

20 UNDERTAKER

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

Charlie Cole

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 ✓ E 60392

REGISTERED NO. E 60392

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Balto Gen Hosp St., 19 Ward)

2-FULL NAME Charlie Cole

(a) RESIDENCE NO. 1618 N. Milton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys Cole

6 DATE OF BIRTH (month, day, and year) Oct 11-1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29		26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER Jos Cole

11 BIRTHPLACE OF FATHER (city or town) N C
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know
(State or country)

14 Informant Gladys Cole
(Address) 1618 Mulberry st

15 Filed 9-8-1930 C. HAMPSON JONES Registrar M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Multiple Fract Skull Motor Cycle he was riding collided head on with another Auto (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (a) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mercy Hospital Balto City

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Hamm M. D.

9/8. 1930 (Address) 1934 E Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dist. National Cem

DATE OF BURIAL Sept 11 d 1930

20 UNDERTAKER A. Jones

ADDRESS 111 S. Eden

...-2-29-28—L. F. S.—500 Bks.

John C. Smith, Sr. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

14-001 E 60393

E 60393 REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1324 Webster ST. 24-33 (WARD)

2—FULL NAME John C. Smith Sr.,

(a) RESIDENCE NO. 1324 Webster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 6 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Smith.

6 DATE OF BIRTH (month, day, and year) Feb, 27, 1856.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74,	6,	14.	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Processor. Ham

(b) General nature of industry, business, or establishment in which employed (or employer) Hamson Packing

(c) Name of employer House.

8 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER ---------Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know.

Informant Carroll Smith.

(Address) 1324 Webster St.

C. HARRISON JONES, M. D.

Filed Sept 8 1930, 19 RRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 8, 1930, that I last saw h alive on Sept 8, 1930, and that death occurred, on the date stated above, at 1215 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. Harrison Jones M. D.

, 19 (Address) 1340 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Sept 11, 193

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Fayette

Marion S. Massey.

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60394

E 60394

REGISTERED NO.

1-PLACE OF DEATH St. Joseph's Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Caroline & Oliver St. 12-50 WARD)

2-FULL NAME Marion S Massey

(a) RESIDENCE NO. 108 S. 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Mary Paisley

DATE OF BIRTH (month, day, and year) June 3/1896

AGE Years	Months	Days	If LESS than 1 day....hrs. or....min.
34	3	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) White Motor Co.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Queen Anne's Co. Md.

10 NAME OF FATHER John Massey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER India Satterfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs. Marion Massey

(Address) Catholic Hospital

Filed 1930 H. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7/30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1930, to Sept. 7, 1930, that I last saw him alive on Sept. 7, 1930, and that death occurred, on the date stated above, at 7 15 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Endocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) M. Sudrin M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Hill Queen Ann Co.

DATE OF BURIAL Sept. 9th 30

ADDRESS 2016 Orleans St

20 UNDERTAKER Phelps & Sons

...c.—1-30—M. & T.—250 Bks

60395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60395

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2916 Auchentorly ST. 15th (WARD)

2-FULL NAME Samuel Patterson White

(a) RESIDENCE NO. 2916 Auchentorly ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of: Martha Mary White

DATE OF BIRTH (month, day, and year): Oct 6" 1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	11	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Custodian &c

(b) General nature of industry, business, or establishment in which employed (or employer): Banking

(c) Name of employer: Safe Deposit Co Balto

BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Matthew White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

Informant: Martha M White wife
(Address) 2916 Auchentorly Ave

Filed 1930 [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1930, to Sept 7, 1930, that I last saw h[illegible] alive on Sept 7, 1930, 1.40 P m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Henry Lee Bartley M. D.

Sept 8 1930 (Address) 2005 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Sept 9 19

20 UNDERTAKER: W. J. Freund Son

ADDRESS: Mt Washington

ec.—1-30—M. & T.—250 Bks

60396 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 60396

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Balto City Hosp ST. 21-24 WARD)

2-FULL NAME Robert Auerhoff

(a) RESIDENCE NO. 706 Mc Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married.

If married, widowed, or divorced HUSBAND of or) WIFE of Ruth Auerhoff.

DATE OF BIRTH (month, day, and year) Jan. 31, 1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	7	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paperhanger.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Oscar Auerhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Welter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hospital Records

(Address)

Filed 1930 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6-30

17 I HEREBY CERTIFY, That I attended deceased from 1-26 , 19 30 to 9-6-30 , 19 30 ,

that I last saw him alive on 9-6-30 , 19 ,

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & Acute

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. 1 mos. 24 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	9/9/1930
20 UNDERTAKER John J. Cowan & Son	ADDRESS 701 Holland

cc.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60397

CERTIFICATE OF DEATH.

E 60397

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Union Memorial Hospital ST. 15-61 WARD)

2-FULL NAME Percy R. Gorrell

(a) RESIDENCE NO. 2900 Garrison Boulevard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced ~~HUSBAND of~~ or ~~WIFE of~~ Ruth Gorrell

DATE OF BIRTH (month, day, and year) June 17th 1898.

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
32	32	2	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER George Gorrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Connolly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records

(Address)

Filed SEP 9 - 1930 [illegible] JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6th 1930.

17 I HEREBY CERTIFY, That I attended deceased from August 25th, 1930, to Sept 6th, 1930,

that I last saw him alive on Sept 6th, 1930,

and that death occurred, on the date stated above, at 8.25 P.M. (Daylight)

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Adynamia ileus

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? undetermined

Did an operation precede death? yes Date of Sept 2nd 1930

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Samuel McClenahan, M. D.

Sept 6 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 9, 1930

20 UNDERTAKER Isaac R. Trancett Son

ADDRESS 1180 W. Royal Ave

C.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 60398

60398

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1912 Homewood Ave. ST. 9-18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Hall

(a) RESIDENCE NO. 1912 Homewood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of or) WIFE of Eliza A. Hall

DATE OF BIRTH (month, day, and year) Dec. 2nd. 1844

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	9	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

10 NAME OF FATHER John W. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant (Address) Miss Bertie M. Hall 1912 Homewood Ave.

Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6th. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 27-, 1930, to Sept. 6-, 1930, that I last saw him alive on Sept. 6-, 1930, and that death occurred, on the date stated above, at 9:55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Right hemiplegia - arterial Sclerosis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) J. Chas Bauer, M. D.

9/E, 1930 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery.

DATE OF BURIAL Sept. 9 1930

ADDRESS

20 UNDERTAKER Chas. L. Crane & Son 1130 W. Royal Ave

c.—1-30—M. & T.—250 Blks

E 60399

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60399

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO. ST. 10-14 WARD)

2-FULL NAME Claud Stroud

(a) RESIDENCE NO. 1219 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Stroud

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36 ?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Shepherd Hill N. C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of

(Address) Balto. City Hosp.

Filed 1930 (J. H. SMITH HOSPITAL) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7-30

17 I HEREBY CERTIFY, That I attended deceased from 6-5-30, 19..., to 9-7-30, 19...,

that I last saw him alive on 9-7-30, 19...,

and that death occurred, on the date stated above, at 12:16 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chr + Acute

(duration) yrs. 11 mos 5 ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. 4 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jas. E. Howell Jr. M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reidsville N.C.

DATE OF BURIAL Sept 11, 1930

ADDRESS 1631 Orleans St

21-30 UNDERTAKER Edward Bryan

ec.—1-30—M. & T.—250 Bks

Time of burial extended to Sept. 7, 4, 1930 J.H. Bridwell Asst. Com of Health

60400 HEALTH DEPARTMENT—CITY OF BALTIMORE 60400

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital (ST. 5-8 WARD)

ITY OF BALTIMORE: (NO.

2-FULL NAME Mary Bellocca

(a) RESIDENCE NO. 207 Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Joseph

DATE OF BIRTH (month, day, and year) May 16, 1902

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	3	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Florida

10 NAME OF FATHER Lawson Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Hospital Records

(Address)

Filed 9-1930 19 Regist. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1930.

17 I HEREBY CERTIFY, That I attended deceased from 9-1-30, 19 , to 9-1, 1930, that I last saw h alive on 9-1, 1930 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Suffocation (Probably Accidental Inhalation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7-1-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) J Lyko, M. D.

9/1, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cem

DATE OF BURIAL 9/4 1930

20 UNDERTAKER P. Madison Mitchell

ADDRESS Havre de Grace Md.

...c.—1-30—M. & T.—250 Bks.

60401 HEALTH DEPARTMENT—CITY OF BALTIMORE 84 ~E 60401

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 Southern av ST. 27-44 WARD)

2-FULL NAME Samuel H. Hoke

(a) RESIDENCE NO. 2410 Southern ave. ST., WARD

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hoke

DATE OF BIRTH (month, day, and year) February 24 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 3 years

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pennsylvania

10 NAME OF FATHER Samuel D. Hoke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Margaret Hershey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

Informant L. Hoke

(Address) 2410 Southern ave

Filed 9-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Sept 7, 1930,

that I last saw h... alive on Sept 7, 1930,

and that death occurred, on the date stated above, at 5.35 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Kyle W. Galley, M. D.

, 19 (Address) 5103 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Sept 10th 1930

20 UNDERTAKER Fred Rossmo

ADDRESS Lora Fullerton

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60402 — 1/188-203 — E 60402

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals St., 46-37 Ward)

2-FULL NAME John William Penn

(a) RESIDENCE NO. Stemmers Run St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 16, 1922

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	7	10	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Md.

PARENTS

10 NAME OF FATHER William J. Penn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Prince Geo. Co., Md.

12 MAIDEN NAME OF MOTHER Lillian Naimaster

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Md.

14 Informant Mrs. Lillian Naimaster
(Address) Stemmers Run, Md.

Filed 9-1930 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Truck + knocked down by auto on left side of road

0 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Comm. Fract. Femur & Multiple Fract. Ribs - Traumatic Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Phila Road

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Penn M. D.

9-9, 1930 (Address) 2939 W. Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Sept. 10 1930
20 UNDERTAKER	ADDRESS
Fredk. Lassahn & Sons	7401 Belair Rd.

ec.—1-30—M. & T.—250 Bks

E 60403 HEALTH DEPARTMENT—CITY OF BALTIMORE 85E 60403

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Maryland University Hospital ST. 25-72 WARD 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO.

2-FULL NAME George A. Brack

(a) RESIDENCE NO. 3109 Wilkins Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5le yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

If married, widowed, or divorced, (or) WIFE of Mamie E. Brack

DATE OF BIRTH (month, day, and year) Sept. 30 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	11	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Building

(c) Name of employer Maryland Dry Docks

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Albert Brack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mamie E. Brack

(Address) 3109 Wilkins Ave.

Filed 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1930, to Sept. 7, 1930,

that I last saw h\ alive on Sept. 7, 1930,

and that death occurred, on the date stated above, at 11:40 P m.

The CAUSE OF DEATH* was as follows:

Fractured Pelvis

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary) Cerebral Edema

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? at work (Maryland Dry Docks)

Did an operation precede death? No Date of 9/4/30

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) George H. Grace, M. D.

9/7, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept. 10, 1930
20 UNDERTAKER Fredk Loeschner Sons	ADDRESS 240 Lexington

ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60404 E 60404

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Rosedale ST. 15-61 WARD)

2-FULL NAME Charles Suttleman

(a) RESIDENCE NO. 2118 Rosedale ST., _____ WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of Ida Suttleman

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant J. Levin (Address) 1439 E Balto St

Filed ..... 19 30 C. Hilton JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-30

17 I HEREBY CERTIFY, That I attended deceased from Sept-1-, 1930, to Sept-1-, 1930, that I last saw him alive on Sept-1, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

1st-9 yrs ago - [illegible] - 2 days

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Lindel, M. D.

9-1 1930 (Address) 2704 Entaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Rosedale — DATE OF BURIAL 9-9- 1930

20 UNDERTAKER Isaac Levin, 1439 E Balto St — ADDRESS

Rec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60405 — 161-602 — E 60405

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 Boarman Ave ST.) (WARD) 58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Matassa

(a) RESIDENCE NO. 2816 Boarman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 minutes ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Sep. 8, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		15 minutes		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Vincent Matassa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Louise Giannini

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Vincent Matassa

(Address) 2816 Boarman Ave

Filed [illegible] 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sep. 8, 1930, to Sep. 8, 1930, that I last saw h[illegible] alive on Sep. 8, 1930 and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Breech Birth with pressure on Umbilical Cord.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene P. Pearson M. D.

9. 8. 1930 (Address) 514 Henry Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 9 1930

20 UNDERTAKER: Frank V. Pipitone — ADDRESS: 201 E. Balto St

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ E 60406

60406

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1710 W Mulberry ST. (WARD) 4-27

2-FULL NAME Henrietta Jones

(a) RESIDENCE NO. 1710 W Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Dec 25 1903

7 AGE — Years: 26 — Months: 8 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Martha Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Martha Jones
(Address): 1710 W Mulberry

15 Filed ..... 1930 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Wm H. Jones, M. D. Coroner

19 ..... (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: Sept 11 1930

20 UNDERTAKER: Joseph A Lively — ADDRESS: 407 W Mount St

rec.—1-30—M. & T.—250 Bks.

2405 E 39940

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001 E 60107

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME PETER LAZAUSKAS

(a) RESIDENCE NO. 21 N. Carey ST ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or WIFE of Elizabeth

DATE OF BIRTH (month, day, and year) 1878

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lithuania

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed 1930, 19 C. H. PEARCE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1930, to Sept 5, 1930, that I last saw him alive on Sept 5, 1930, and that death occurred, on the date stated above, at 9:40 A.m.

The CAUSE OF DEATH* was as follows:

acute myeloid leukemia

(duration) yrs. mos 35 ds.

CONTRIBUTORY (Secondary) otitis media, pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of residence

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis? blood culture

(Signed) Benj. M. Baltrop, M. D.

Sept. 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Sept 9 1930

UNDERTAKER Chas B. Kruhaucklas

ADDRESS 632 S Paca St

30—M. & T.—100 B—50L

E 60408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60408

1-PLACE OF DEATH (If in hospital give its NAME instead of street and number) 2400 Block Stockton St. WARD

CITY OF BALTIMORE

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas A Lucey

(a) RESIDENCE NO. 507 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Viola

6 DATE OF BIRTH (month, day, and year): Jan 24 1888

7 AGE: Years 42 | Months 7 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: David Lucey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rebecca Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Viola Lucey

(Address): 507 Baker

15 Filed ____, 192 ____ HARRISON JONES, M. D. Registrar

By ____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Lucey (Inquest, autopsy or inquiry.) find that said deceased came to ____ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Error of diet

(duration) 5 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) Harrison Jones, Coroner, M. D.

19 (Address) Bromo

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 9 9 1930

20 UNDERTAKER: Samuel P Hemsley

ADDRESS: 578 N Eddle

30—M. & T.—100 B—50L

E 60409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 60409

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. ST. 15-21 WARD)

2-FULL NAME Maybelle Lancaster

(a) RESIDENCE NO. 1737 Baker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Richard Lancaster

11 BIRTHPLACE OF FATHER (city or town) Portland (State or country) Maine

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Ernest Lancaster

(Address) 1737 Baker

15 Filed ..... Registrar

P 5 - 1330

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Geo. Pegram, M. D. Coroner

(Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Sept 19, 1930

ADDRESS 1745 Ashland Ave

20 UNDERTAKER Mrs. R. A. Elliott

Rec.—1-12-23—M&T—500 Blks.

E 60410

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

49 E 60410

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3430 Belair Road ST. (8-45 WARD)

2-FULL NAME Apallonia Schoenig

(a) RESIDENCE NO. 3430 Belair Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Schoenig

DATE OF BIRTH (month, day, and year) Dec. 2/1850

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
79	9	5		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John Mathias

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Kunigunda Schick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Nicholas Schoenig

(Address) 3430 Belair Rd

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 7, 1930, that I last saw her alive on Sept 6, 1930, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Osteosarcoma (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Cadwallader Gaw, M. D.

19 (Address) 1937 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Sept 10 1930

DATE OF BURIAL

20 UNDERTAKER Joseph Henderson

ADDRESS 307 Kentucky Ave

C. HANSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60411

101-001 ✓ E 60411

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 730 Grindall Court. St. 24-33 (Ward)

2-FULL NAME Hattie Smith.(C)

(a) RESIDENCE NO. 730 Grindall Ct. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow.

5a If ~~married, widowed, or divorced~~ (or) WIFE of Henry Taylor.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant William Smith.(C)
(Address) 730 Grindall Ct.

15 Filed ... 1930 ... C. Hilary Jones M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 7, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Einhaud M. D.

9/8, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Laurel

DATE OF BURIAL Sept 10 1930

20 UNDERTAKER R L Parker 36 Seven Arabia

ADDRESS

c.—1-30—M. & T.—250 Bks.

E 60412 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60412

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO. 16-23 44

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Richard Hicks

(a) RESIDENCE NO 1124 Carrollton Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married

If married, widowed, or divorced HUSBAND of or) WIFE of ?

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
42		—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

BIRTHPLACE (city or town) (State or country) ? Va

10 NAME OF FATHER Danny Hicks

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Clarke

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Va.

Informant ..... (Address) Baltimore City Hosp.

Filed ... 1930 ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7-30

17 I HEREBY CERTIFY, That I attended deceased from 7-24-, 1930, to 9-7-, 1930, that I last saw h[illegible] alive on 9-7-, 1930, and that death occurred, on the date stated above, at 9 3/4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum with metastasis to Liver

(duration) unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of unknown

Was there an autopsy? no yes

What test confirmed diagnosis? Clinical & Operation.

(Signed) Fred M. Dunkerly, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 10, 1930

20 UNDERTAKER Harmon & Smith Woodlawn

ADDRESS Cemetery

ec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60413 E 60413

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 2424 Rogers Ave ST. 27-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Lauer

(a) RESIDENCE NO. 2424 Rogers Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) June 4/1869

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	8	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employee Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Goods

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Martin Polan Leonard Edwards

(Address)

Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Sept 9, 1930, that I last saw him alive on Sept 9, 1930, and that death occurred, on the date stated above, at 1215 A m.

The CAUSE OF DEATH* was as follows:

Thrombosis coronary artery

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) M L Breitstein, M. D.

, 19 (Address) 1714 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai

DATE OF BURIAL Sept 10 1930

ADDRESS Eutaw & Lexington

20 UNDERTAKER Karl Sondheim & Son

1902 Eutaw Place

ALEX. JONES, M. D.

ec.—1-30—M. & T.—250 Bks

E 60414 E 60414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 100-001

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 33rd. st at Colvert St. 70-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Robert Mattes

(a) RESIDENCE NO. 502 S. Payson st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 5, 1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Herman Mattes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elsie Hilo.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mother.

(Address) [illegible]

Filed 9-1930 C. H. BOYLE JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7/30.

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to Sept 7, 1930, that I last saw him alive on Sept 7, 1930, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Malnutrition; secondary anemia;

(duration) yrs. 3 mos 22 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia;

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? 502 S Payson st.

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Frances W. Gluck, M. D.

9/7, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery Md.	Sept 1930
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	904 E Eager

...c.—1-30—M. & T.—250 Bks

E 60415

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-201 E 60415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 23-31 ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie Gaskins

(a) RESIDENCE No. 160 W. Hamburg ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Harry

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N. C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of (Address) Balto. City Hosp.

15 Filed SEP 9 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7-30

17 I HEREBY CERTIFY, That I attended deceased from 8-18-30, 19 ..., to 9-7-30, 19 ..., that I last saw h im alive on 9-7-30, 19 ..., and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Alcoholism Chronic & Acute

(duration) ... yrs. 1 mos 22 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Shands Jr, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL
SEP 9 - 1930

...c.—1-30—M. & T.—250 Blks.

E 60416 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60416

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH Baltimore City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 27-44 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Samuel

(a) RESIDENCE No. 402 S Parkside Drive ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
5		—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) ? 6 15

(c) Name of employer ?

BIRTHPLACE (city or town) ?
(State or country) Pa.

10 NAME OF FATHER Isaac Samuel

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Hirsky

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Pa.

14 Informant Rynda ?
(Address) Baltimore City Hospitals

Filed 9-1930, 19 RPR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7-30

17 I HEREBY CERTIFY, That I attended deceased from 6-18-, 1930, to 9-7-, 1930, that I last saw h[illegible]alive on 9-7-, 1930, and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of shoulder
Hemiplegia Arteriosclerosis.

(duration) yrs. [illegible] mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 6-20-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical Obsn.

(Signed) Fred M. Ducksworth, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER H. Commissioner Health — ADDRESS SEP 9 - 1930

H. FRANKLIN JONES, M. D.

ec.—1-30—M. & T.—250 Bks.

E 60417 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60417

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hosp. (No. ..... ST. 6-10 WARD)

CITY OF BALTIMORE: (No. .....)

2-FULL NAME Michael A. Bloom

(a) RESIDENCE NO. 128 N Modeira ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of —

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

BIRTHPLACE (city or town) (State or country) Finland

10 NAME OF FATHER John Bloom

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Finland

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Finland

14 Informant Friends (Address) Baltimore City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-4-30

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1930, to 9-3-, 1930, that I last saw h. alive on 9-4-, 1930, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus with metastasis to liver

(duration) Months Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 4-14-30

Was there an autopsy? no

What test confirmed diagnosis? Ageutic Exam.

(Signed) Fred M. Buckwalter, M. D.

, 19 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

20 UNDERTAKER Commissioner Health

ADDRESS .....

DATE OF BURIAL 19

SEP 9 - 1930

C. HARRIS JONES, M. D.

ec.—1-30—M. & T.—250 Blks

E 60418 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60418

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.

2-FULL NAME John Turner

(a) RESIDENCE NO. 1128 McCulloh st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) June 16, 1891

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	7	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER John Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliza Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Hospital Records

(Address) JOHNS HOPKINS HOSPITAL

Filed SEP 9 1930, 19 C. HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to Sept. 1, 1930, that I last saw him alive on Sept. 1, 1930, and that death occurred, on the date stated above, at 11.55 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. Unknown mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ward Tenner, M. D.

9-1, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL 19

ADDRESS

SEP 9 - 1930

Commissioner Health

ec.—1-30—M. & T.—250 Bks.

E 60419 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60419

CERTIFICATE OF DEATH.

161-00

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 441 W. Biddle st. ST. 11-24 WARD)

2-FULL NAME Infant of Benjamin & Margaret Fletcher

(a) RESIDENCE NO. 441 W. Biddle st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

If married, widowed, or divorced: HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year): Sept 8th 1930

AGE	Years	Months	Days	If LESS than 1 day, 7 hrs. or mm.

OCCUPATION OF DECEASED: —

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

BIRTHPLACE (city or town) (State or country): Balto md

10 NAME OF FATHER: Benjamin Fletcher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Margt Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: Margaret F Fletcher

(Address) 441 W. Biddle st

Filed: 9-10-1930 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Sept 8th, 1930, that I last saw h... alive on Sept 8th, 1930, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth - 6 months

Atelectasis

(duration) ... yrs. ... mos 7 hrs.

CONTRIBUTORY (Secondary) — (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Harry F Brown, M. D.

9/9, 1930 (Address) 1916 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: SEP 9 - 1930

20 UNDERTAKER: Commissioner Health — ADDRESS

ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60420

E 60420

CERTIFICATE OF DEATH.

28-65 131

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 Talbot Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta S. Pels

(a) RESIDENCE NO. 2403 Talbot Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of Edward S. Pels

DATE OF BIRTH (month, day, and year) Sept. 1. 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	0	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Henry Straus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Wilhelmena Marcus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover

14 Informant (Address) Mrs. Altman Buffalo, N.Y.

15 Filed ..... 19 ..... Registrar .....

Date .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9.1930.

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to Sept 9, 1930.

that I last saw him alive on Sept 9, 1930,

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pyonephroses Bilateral

May 6/30 to Sept 9/30

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Uremia Sept 6/30 to Sept 9/30 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Sydney Wallenstein, M. D.

, 19 (Address) 2042 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Crematory

DATE OF BURIAL 9/11/ 1930

20 UNDERTAKER David Sondheim & Son

ADDRESS 1903 Eutaw Place

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60421

CERTIFICATE OF DEATH

89 E 60421

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 718 N. Patterson Park Ave ST., 7-17 WARD)

2—FULL NAME Harry Ely

(a) RESIDENCE NO. 718 N. Patterson Park Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced, HUSBAND of May Ely

DATE OF BIRTH (month, day, and year) Aug. 4, ~~1865~~ 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: U.S. Coast & Geodetic Service

(b) General nature of industry, business, or establishment in which employed (or employer): gov

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

10 NAME OF FATHER: Samuel Ely

11 BIRTHPLACE OF FATHER (city or town) (State or country): Middletown Conn.

12 MAIDEN NAME OF MOTHER: Catherine Kennard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

Informant: Mrs May Ely

(Address): 718 N. Patterson Park Ave

Filed SEP 9 1930, ALAN P. DAWSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 7. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1930, to Sept 7, 1930

that I last saw him alive on Sept 7, 1930

and that death occurred, on the date stated above, at 7:00 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan P. Dawson, M. D.

9/9, 1930 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sep; 10/30
20 UNDERTAKER	ADDRESS
Hughes & Son Inc	424 N. Broadway

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60422

CERTIFICATE OF DEATH

84 E 60422

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Park Ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjamin W. Robinson

(a) RESIDENCE NO. 1823 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Anne E Robinson

DATE OF BIRTH (month, day, and year): Jan 14/1866

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	26	

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Consulting Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Harrisburg Pa

10 NAME OF FATHER: George Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Isle of Man Great Britain

12 MAIDEN NAME OF MOTHER: Eliz Daniels

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Madrid

Informant: Benj W Robinson Jr.

(Address): 1823 Park Ave

Filed: 1930 Mar

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 . 1930 . to Sept 9 . 1930

that I last saw h alive on Sept 8 . 1930

and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Acute pleurisy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

9/9 . 1930 (Address) 720 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Sept 11 1930

UNDERTAKER: J. Ahearn & Son

ADDRESS: 2432 Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60423

168 E 60423

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2700 Ockley or St. 27-5 (Ward)

2-FULL NAME J. Roland Corradini

(a) RESIDENCE NO. 2700 Ockley or St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Margaret Corradini

6 DATE OF BIRTH (month, day, and year) Jan 15 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	37	7	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Storekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Lumber
(c) Name of employer: David Lupton Co

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER J. J. Corradini

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Carter

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Margaret Corradini
(Address) 2700 Ockley ave

15 Filed ..... 19..... Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hanging by Neck

Suicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

9/9, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery Landon Park

DATE OF BURIAL 9/10 1930

20 UNDERTAKER W M Cook

ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60424

CERTIFICATE OF DEATH

101-001 ✓ E 60424

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 255 S Caroline St., 1-3 Ward)

2-FULL NAME Camillo Margola

(a) RESIDENCE NO. 2535 Fait ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 26 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	1	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Dominick Margola

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Carlena Rossi

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Dominick Margola
(Address) 2535 Fait ave

15 1930 C. HAMPSON JONES, M. D. Registrar
By RMP

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) James M Fenton M. D.
9/9. 1930 (Address) 2012 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 10 1930
UNDERTAKER Wendell & Lippel	ADDRESS 3661 Eden

2-29-28—L. F. S.—500 Blks.

E 60425

HEALTH DEPARTMENT—CITY OF BALTIMORE

117 E 60425

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Maryland General Hospital ST. Madison & Howard WARD) 26-27

2—FULL NAME William Magenuppe

(a) RESIDENCE NO. 415 Brice ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. 6 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	~~Widower~~ Married

If married, widowed, or divorced (or) WIFE of Mame Mae Magenuppe

~~HUSBAND~~ of Wilhelmina Magenuppe

DATE OF BIRTH (month, day, and year) March 8, 1896

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
34		6	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware Store

(c) Name of employer J. B. Rafferty.

BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

10 NAME OF FATHER J. William Magenuppe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ella Kiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgetown D.C.

Informant Hospital Records

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 9, 1930,

that I last saw h[illegible] alive on Sept 9, 1930

and that death occurred, on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis, Appendix & general peritonitis

CONTRIBUTORY (Secondary) (duration) yrs. mos. 12 ds. Paralytic ileus

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 415 Brice St.

Did an operation precede death? Yes Date of Sept 8 1930

Was there an autopsy? Done.

What test confirmed diagnosis? Clinical

(Signed) Robert V. Emmett, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 9/12 19 30

20 UNDERTAKER [illegible] Cook 1217 St Paul St

ADDRESS

OCT 10 1930, 19 CHARLES P. JONES, M. D. Registrar

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

165 ✓

E 60426

REGISTERED NO. E 60426

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 60426

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hosp. St., Ward) R. 25-27

2-FULL NAME Harasom Borysow.

(a) RESIDENCE NO. 4204 Grace Court Curtis Bay. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 17 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of ~~WIFE of~~ Pauline Borysow.

6 DATE OF BIRTH (month, day, and year) April 6, 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	41	5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer): 015
(c) Name of employer:

9 BIRTHPLACE (city or town) Russia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Pauline Borysow. (wife)
(Address) 4204 Grace Court. Curtis Bay.

15 Filed 10 1930 19 H. FRANCIS JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 7, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paris Green poisoning.
suicide.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) C. M. Leonhardt, M. D.

9/9, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's (Hampden)

DATE OF BURIAL: 9/10/1930

20 UNDERTAKER: Wm Cook 1217 E Paul st

ADDRESS

Dr Riblett 2220 Garrison Blvd

Spec.—1-30—M. & T.—250 Blks.

E 60427 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60427

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3106 Garrison Blvd ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John William Roman

(a) RESIDENCE NO. 3106 Garrison Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mand Roman

DATE OF BIRTH (month, day, and year) Oct 3. 1878

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	11	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John E Hurst Co

BIRTHPLACE (city or town) (State or country) Washington D C

10 NAME OF FATHER John A Roman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Gregory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Mand Roman (Address) 3106 Garrison Blvd

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1930, to Sept 9, 1930, that I last saw h alive on Sept 8, 1930, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis — interstitial nephritis

Chronic - interstitial Nephritis about 1 yrs. mos ds.

(duration)

CONTRIBUTORY (Secondary) myocarditis - Nephritis about 2½ yrs. mos. ds.

(duration)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + Laboratory

(Signed) W S Riblett M. D.

9-9, 1930 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

20 UNDERTAKER William Cook

DATE OF BURIAL 9/11 1930

ADDRESS 1702 E Pratt St

...c.—1-30—M. & T.—250 Blks.

E 60428

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60428

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital
CITY OF BALTIMORE: (No. Caroline & Eden ST., 4-18 WARD)

2-FULL NAME Helen Anderson

(a) RESIDENCE NO. 1906 Aisquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) 1915

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Johnson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant John Anderson
(Address) 1906 Aisquith St

15 Filed ..... 19..... C. HARRY JONES, ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7/30

17 I HEREBY CERTIFY, That I attended deceased from August 18, 1930, to Sept. 7, 1930, that I last saw her alive on Sept. 7, 1930, and that death occurred, on the date stated above, at 4 45 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Rheumatic Carditis Vavular Disease (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Wright Sands, M. D.

, 19 (Address) Wright & Hoff

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Sept 9 1930

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1725 Ashland Ave

...c.—1-30—M. & T.—250 Bks.

60429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/E 60429

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2429 Barclay St. (ST.) 12-50 (WARD)

2-FULL NAME Ann Marie Abbey

(a) RESIDENCE NO. 2429 Barclay St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Edward B. Abbey

DATE OF BIRTH (month, day, and year) August 2nd. 1901

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	1	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Charles Chapple

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Bridget Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Edward B. Abbey

(Address) 2429 Barclay St.

Filed ...01930..., 19... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8th. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 8, 1930.

that I last saw h alive on Sept 7, 1930

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) To my knowledge

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clynical

(Signed) James M Fenton M. D.

Sept 8 1930 (Address) 7002 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL Sept. 11, 30.

ADDRESS

UNDERTAKER Chas. H. Graves & Son 118 W. Mt. Royal Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C0430 — 11 VE 60430

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 12 N. Hill St. St. 22-30 Ward)

2-FULL NAME Florence Burk.

(a) RESIDENCE NO. 12 N. Hill St. St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 10 mos 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed or divorced~~ (or) WIFE of John F. Burk.

6 DATE OF BIRTH (month, day, and year) October 21, 1881

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48	10	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER William H. Taylor.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Martha E. Ectons.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant John F. Burk. (husband.)
(Address) 12 N. Hill St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion.

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto W. Einhardt M. D.

9/9. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Sept. 11" 1930

20 UNDERTAKER Joseph B Cook ADDRESS 603 N Gallo St

SEP 10 1930

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60431

CERTIFICATE OF DEATH.

117 E 60431

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 20-69 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr James D. Bunce

(a) RESIDENCE NO. 506 Brunswick ST., WARD

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Levana Bunce

6 DATE OF BIRTH (month, day, and year) Aug. 26, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
32		-	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Mechanic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Wilkens Ave. Service Station

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James D. Bunce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Etta Cropsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. William Bunce

(Address) 1509 N. Durham St.

15 Filed SEP 10 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-9 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-1-1930, to 9-9, 1930, that I last saw h[illegible] alive on 9-9, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ileus due to band of omentum occluding ileum about 8" above ileo cecal junction.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? appendectomy.

Did an operation precede death? Yes. Date of 9/1/30

Was there an autopsy? partial

What test confirmed diagnosis?

(Signed) Robt. Glover, M. D.

9/9/1930 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

UNDERTAKER [illegible]

DATE OF BURIAL Sept 11 1930

ADDRESS 1003 West Baltimore St

ec.—2-29-28—L. F. S.—500 Bks.

60432 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 60432

CERTIFICATE OF DEATH

1—PLACE OF DEATH Maryland General Hosp REGISTERED NO. 8-16

ITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Chester Becker

(a) RESIDENCE NO. 2327 E. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

If married, widowed, or divorced HUSBAND of Mrs Chester Becker (or) WIFE of Elise Becker

DATE OF BIRTH (month, day, and year) Dec. 7, 1882

AGE 47 Years	Months	Days	If LESS than 1 day, hrs. or min
	8- 9	7- 2	

OCCUPATION OF DECEASED Chief Clerk

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Standard Oil Co

BIRTHPLACE (city or town) (State or country) Balto md

10 NAME OF FATHER Mr Lewis Becker

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

Informant Hospital records

(Address)

Filed 10 1930 C. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 9, 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1930, to Sept 9, 1930, that I last saw him alive on Sept 8, 1930 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows: Stand.

Carcinoma head of Pancreas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert L. Arnold M. D.

19 (Address) Md. General Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem DATE OF BURIAL Sept. 12 1930

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N Balto

Dr. Reich to see Dr. Barrow.

ec.—1-30—M. & T.—250 Bks

E 60433 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60433

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Howard Williams

(a) RESIDENCE NO. 1134 N. Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Minnie

DATE OF BIRTH (month, day, and year) April 10, 1882

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	4	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Kingsville

(State or country) Md.

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Lizzie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

Informant Records of

(Address) Balto. City Hospitals

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6-30

17 I HEREBY CERTIFY, That I attended deceased from 8-20-30, 19..., to 9-6-30, 19...,

that I last saw him alive on 9-6-30, 19...,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute.

Hypertension

(duration) yrs. 9 mos 26 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical

(Signed) Jas Thomas Jr, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Sept 10, 1930

20 UNDERTAKER Thomas E. Kelsam.

ADDRESS 1303 Presstman St

0 1930 CLARENCE JONES, V. S.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90E 60434

60434

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 509 N.Gilmor St (St.) (Ward) 14-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Tunstall

(a) RESIDENCE NO. 509 N.Gilmor St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced (HUSBAND) of (or) XXXXXX Betty Tunstall

6 DATE OF BIRTH (month, day, and year) Jan 15 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Not employed

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Henry Tunstall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Betty Tunstall

(Address): 509 N.Gilmor St

15 Filed 10 1930 19 C. H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1 1930, 19, to Sept 7 1930, 19, that I last saw him alive on Sept 7 1930, 19, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation & Acute Dilatation of the Heart

(duration) X yrs. 4 mos 7 ds.

CONTRIBUTORY (Secondary) Anasarca

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles L. Clark, M. D.

9/9.30 (Address) 3214 Piedmont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetary — DATE OF BURIAL: Sept 10, 1930

20 UNDERTAKER: Mrs. Kate P. Williams — ADDRESS 3221 Woodstock

ec.—2-29-28—L. F. S.—500 Bks.

60435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 60435

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No.) Md. General Hospital ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Maher

(a) RESIDENCE NO. 1129 Bayard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 9/8/30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				9 hrs 15 Min

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md. Md. Gen. Hosp

10 NAME OF FATHER William J. Maher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mildred Downey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Hospital Records

(Address)

Filed [illegible] 1930 C. EMERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/30

17 I HEREBY CERTIFY, That I attended deceased from 9-8-, 1930, to 9/9, 1930, that I last saw her alive on 9/9/30, 19, and that death occurred, on the date stated above, at 2.05 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 months).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post Mortem Clinical

(Signed) Robert H. Chenoweth, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 9/10 1930

21 UNDERTAKER: Fred'k. A. Cole

ADDRESS 1230 N. Fremont Ave

ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60436

CERTIFICATE OF DEATH.

129 E 60436

1-PLACE OF DEATH Union Hosp. 14-20 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Fleischman

(a) RESIDENCE NO. 2060 Linden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

7 DATE OF BIRTH (month, day, and year) 10-21-1903

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	10	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md

10 NAME OF FATHER Henry Fleishman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Eva Kronsberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Levine (Address) 1439 E Balto st

15 Filed TO 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-9-30

17 I HEREBY CERTIFY, That I attended deceased from 9-6, 1930, to 9-9, 1930, that I last saw him alive on 9-9, 1930, and that death occurred, on the date stated above, at 12 50 P m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No Clinical Dx

What test confirmed diagnosis?

(Signed) Milton Blush, M. D.

, 19 (Address) Union Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shaw Southern Ave. DATE OF BURIAL 9-10- 1930

20 UNDERTAKER Jack Levine, 1439 E Balto st ADDRESS

Cor.—10-10-20—A Co.—100 Bks.

E 60437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 E 60437

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital St. 14-20 (Ward)

2-FULL NAME Francis A Taylor

(a) RESIDENCE NO. 711 N. Gilmor St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Taylor

6 DATE OF BIRTH (month, day, and year) March 27 1899

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Ryley Estate
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo A Taylor

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto Md

14 Informant Mrs Anna Taylor (Wife)
(Address) 711 N Gilmor St.

15 Filed ..... 19 ..... JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-9 1920

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto truck he was driving in collision with Taxicab at intersection

2 hrs (duration) ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract. C.C. Skull

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Read & Chas

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) I. Strauss, M. D.

9 19 20 (Address) 2939 W Eldorado

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 12 1920
20 UNDERTAKER Henry Koch Sons Inc	ADDRESS 1301 E Eager St

10 1330

-30—M. & T.—100 B—50L

E 60438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60438

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Ensor St. ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence. Irene. Putens

(a) RESIDENCE NO 1102 Ensor St. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 7 mos. 28 ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Mr. Charles. A. Putens

6 DATE OF BIRTH (month, day, and year) Jan.-10-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) House wife 0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore,

14 Informant Mr. Charles. A. Putens

(Address) No. 1102 Ensor St.

Filed OCT 10 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept.-8-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hist[illegible] History

(Signed) [signature] Coroner, M. D.

9/1, 19 30 (Address) [illegible] E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Sept. 12 1930

20 UNDERTAKER Henry Poe[illegible] Sons Inc. ADDRESS 130 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

60439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 60439

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 E. 20th St. 9-18 WARD)

2-FULL NAME Mary Teresa Mc Ginn

(a) RESIDENCE NO. 513 E. 20th St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1871

7 AGE: Years 58 Months 8 Days 24 (23) If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Claim Agent U. E. R.R.

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Bernard Mc Ginn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Hayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) John J. Mc Ginn (Bro.) 513 E. 20th St.

15 [illegible] Registrar

P 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 9 - 1930

17 I HEREBY CERTIFY, That I attended deceased from 2 - 17 - 1930 to 9 - 9 - 1930,

that I last saw her alive on 9 - 9 - 1930

and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Heart Block

Cardiac Dilatation

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus - Arterio - Sclerosis & Hypertension (duration) ..... yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Dr. O. B. Hebert, M. D.

, 19 (Address) 2302 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Sept 13, 1930

20 UNDERTAKER: Chas. F. Kraus & Son

ADDRESS: 1810 W. Royal Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-103 E 60440

CERTIFICATE OF DEATH

60440

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital Ward)

2-FULL NAME Henry Grau

(a) RESIDENCE NO. 221 N. Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 years mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21/28

7 AGE	Years	Months	Days	IF LESS than 1 day hrs or min.
	1	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Wm J Grau

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Estelle Wilkinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Wm Grau
(Address) 221 N. Caroline

15 Filed 9 10 1930 HARRY C. HARRISON JONES, M. D. Registrar

0 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & knocked down by automobile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Hemorrhage
Possible Fract Skull (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in front of 0 N Caroline

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. C. Runce M. D.

9 10 1930 (Address) 2939 Mt Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	9/11 1930
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Eutaw St

4c—2-29-28—L. F. S.—500 Bks.

E 60441 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60441

CERTIFICATE OF DEATH

REGISTERED NO. 49

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 27-49 WARD)

2—FULL NAME Archie C. Bortner

(a) RESIDENCE NO. 1836 Poland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

If married, widowed, or divorced HUSBAND of (or) WIFE of Ora Bortner

DATE OF BIRTH (month, day, and year) Dec 8 1887

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	8	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pennsylvania Pa

10 NAME OF FATHER Daniel M. Bortner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Lena Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Hospital Records

(Address)

Filed SEP 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/30

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to Sept 9, 1930, that I last saw h[illegible] alive on Sept 9, 1930, and that death occurred, on the date stated above, at 12.00 P.M. D.S.T.

The CAUSE OF DEATH* was as follows:

(Carcinoma of Bladder (Papillare) ?

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia Cerebral

(duration) yrs 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 23 1930

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Biopsy

(Signed) Robert J. Clemente, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL Sept 12, 1930

20 UNDERTAKER Chenowith Bros ADDRESS 3[illegible] Edmondson

Rec.—1-30—M. & T.—250 Bks.

E 60442

E 60442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4335 Restertown Rd ST., 15 WARD)

2-FULL NAME Mr Lawrence A Jacobs.

(a) RESIDENCE NO. 4335 Restertown Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

6 If married, widowed, or divorced
HUSBAND of
WIFE of Annie E. Jacobs.

DATE OF BIRTH (month, day, and year) Apr 7, 1863

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67.	5	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) Tinsmith

(c) Name of employer Tin Decorating Co. Baltimore.

BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo. J. Jacobs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER M. Lacey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore.

14 Informant Annie Jacobs
(Address) 4335 Harford Rd

15 Filed 9/12 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1930, to Sept 10, 1930.

that I last saw him alive on Sept. 9, 1930,

and that death occurred, on the date stated above, at 12.30 AM

The CAUSE OF DEATH* was as follows:

Mitral regurgitation,
myocarditis, with
marked arteriosclerosis.

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation
Pulmonary Edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs.

(Signed) Edward S Johnson, M. D.

9/10, 1930 (Address) 1216 St Paul St Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	9/12 1930
20 UNDERTAKER	ADDRESS
Wilson Co	1217 St Paul St

Dec.—1-30—M. & T.—250 Blks.

Dr Hack 936 E. Monument St / Van 5742 ✓ E 60443 8 to 9:30 Daylight

E 60443

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1164 E. North Ave St. 3-20 WARD

2-FULL NAME Elias A. Buckingham

(a) RESIDENCE No. 1164 E. North Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word)
Male	White	Widowed

6 If ~~married, widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Francis D.

DATE OF BIRTH (month, day, and year) May 25th 1849

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	3	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith do

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Elijah Buckingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ann Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Harvey E. Buckingham (Address) 1164 E. North Ave

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1930 to Sept 9, 1930, that I last saw ~~him~~ alive on Sept 8, 1930, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. J. Peck M. D.

4/9, 1930 (Address) 1936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stone Chapel Cemetery

DATE OF BURIAL 9/12/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 Park St

Spec.—1-30—M. & T.—250 Bks.

60444

Dr 704 Catrudd St ✓ 2x3E 60444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 5606 York Road ST. 27-48 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M McPherson

(a) RESIDENCE NO. 5606 York Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 12. 1908

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hochschild Kohn Co

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel McPherson

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Margaret Marshall

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balt Md

14 Informant Margaret McPherson

(Address) 5606 York Rd

Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M.

10-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1930, to Sept. 9, 1930, that I last saw her alive on Sept 9, 1930, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

7

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Laboratory

(Signed) J Hamilton Jones M.D.

9/10, 1930 (Address) 11 W Cary St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 9/12 1930

20 UNDERTAKER W M Cook — ADDRESS 1217 Park St

-30—M. & T.—100 B—50L

E 60445

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60445

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp ST. 11-24 WARD)

2-FULL NAME Roselle Parker

(a) RESIDENCE No Cambridge Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Md Gen Hosp

(Address) Madison & Rutland

15 Filed ..... 192 ..... Registrar

0 1930 THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

2nd & 3rd degree burns

(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? On Schooner Agnes L. Leonard

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) ..... Coroner, M. D.

Sept 5th 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS SEP 10 1930

Dec.—6-9-19—H. P. Co.—1000 Bks.

E 60440

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 2905 Poplar Terrace ST. 15th WARD)

REGISTERED NO. 1560 1429

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Sophia Thomson.

(a) RESIDENCE NO 2905 Poplar Terrace ST., 15th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

6a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of: Charles Carroll Thomson.

7 DATE OF BIRTH (month, day, and year): Dec. 29. 1870

8 AGE — Years: 60 — Months: 8 — Days: 11 — If LESS than 1 day, ... hrs. or ..... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

11 NAME OF FATHER: John Edward Cole

12 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

13 MAIDEN NAME OF MOTHER: Mary Elizabeth Black

14 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Elizabeth Carroll Garey
(Address) 2905 Poplar Terrace.

15 Date Received: OCT 1 0 1930 Registrar: C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Sept. 9, 1930, that I last saw h.e.r. alive on Sept. 9, 1930, and that death occurred, on the date stated above, at 5.35 P. m.

The CAUSE OF DEATH* was as follows:

Acute myocardial dilatation

Mitral Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis. Chronic Interstitial Nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes.

Did an operation precede death? No Date of .

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Charles Luther Warner, M. D.

, 19 (Address) 3312 Eguton Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Sept 12 1930

20 UNDERTAKER: Chas. J. Black — ADDRESS: 742 W Worth ave

sec.—1-30—M. & T.—250 Bks.

40489
Surg.
E 60447

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60447

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 19 WARD)

2-FULL NAME Louise Crumpler

(a) RESIDENCE NO. Salisbury N. C. ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 2 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 5, 1917

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	8	5	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) N. C.

10 NAME OF FATHER Blackman Crumpler

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Lena Royal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 10 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) SEP 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1930, to Sept 10, 1930, that I last saw her alive on Sept. 10, 1930, and that death occurred, on the date stated above, at 1 28 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral glioma

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? yes Date of 8-10-30

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) Fredk W. Gilde M. D.

, 19 (Address) Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury N C

DATE OF BURIAL 9/10/30

20 UNDERTAKER Joseph Owens

ADDRESS 221 Bway

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60448 — 90 E 60448 — REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 S. Ellwood Ave. ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ADAM RIEDEL

(a) RESIDENCE NO. 233 S. Ellwood Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Riedel

DATE OF BIRTH (month, day, and year) February 12, 1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	6	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 8 years

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Christopher Riedel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Foerster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mr. Melvin Foerster

(Address) 233 S. Ellwood Ave.

Date 8-1930, 19 — C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930, to Sept 8, 1930

that I last saw h alive on Sept 7, 1930

and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Cystic duct obstruction, Chs. Cholangitis

Arteriosclerosis. Chs myocarditis

(duration) yrs. mos. 2' ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation (doration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 7

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. data

(Signed) Leo Steinberg, M. D.

, 19 (Address) 3034 Walbrook

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cem.

DATE OF BURIAL: Sept. 11, 19 30

ADDRESS: Baltimore St. & Broadway.

20 UNDERTAKER: Henry Sander & Sons. Inc.

Spec.—1-10-21—M&T—1500 Bks.

E 60449

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60449

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 20-71 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary C. Scheve

(a) RESIDENCE NO. 301 S. Augusta Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Scheve

6 DATE OF BIRTH (month, day, and year) Feb. 11 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clement Ostendorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mr Charles Scheve 301 S. Augusta Ave

15 Filed 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-4 1930, to 9-8 1930, that I last saw her alive on 9-8 1930, and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Hypertension Cardio Vascular disease

Myocarditis

Auricular fibrillation

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? (No) Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Robt Feaver M. D.

19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Sept 11 1930

20 UNDERTAKER Margaret H. Flynn

ADDRESS 142 N Eutaw St

ec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60450 + 185E 60450

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. 12-49 WARD)

2-FULL NAME Mr. Sol Hobleitzell

(a) RESIDENCE NO. Bel Air, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Feb. 29/1875

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55 years.	6	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Newspaper reporter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Rev. H.G. Hobleitzell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Follen.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records.

Filed SEP 13 1930 H. D. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10/30.

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930 to Sept. 10, 1930.

that I last saw him alive on Sept 10, 1930.

and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of humerus, left, Colle's fracture left.

C/K. Comer & Thomsen / over

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage. Myo Cardits, Chronic

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Bel Air.

Did an operation precede death? yes Date of Aug. 6/30.

Was there an autopsy?

What test confirmed diagnosis? X-Rays.

(Signed) Samuel McLanahan, M. D.

Sept 19 30 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	Sept 13 1930
20 UNDERTAKER	ADDRESS
Dean & Tatro	Bel Air Md

30—M. & T.—100 B—50L

E 60451

HEALTH DEPARTMENT—CITY OF BALTIMORE

Pronounced dead N. B. Hotel

CERTIFICATE OF DEATH

REGISTERED NO. E 60451

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Full-2700 N. Lafayette ave or Maynard. ST., 70-69 WARD)

2-FULL NAME William A. Histerman

(a) RESIDENCE NO. 2732 N. Lafayette ST., ... WARD .....
(Usual place of abode) 2732 (If non-resident give city or town and State)
Length of residence in city or town where death occurred 57yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cecelia Histerman

6 DATE OF BIRTH (month, day, and year) May 27. 1873

7 AGE: Years 57 | Months 3 | Days 13 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Check Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Western Maryland

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS
10 NAME OF FATHER August Histerman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Pindle
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Albert R. Histerman
(Address) 2732 N. Lafayette Ave

15 Filed 1-1 1930 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10 19 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Pneumonia

(duration) 2 days yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2700 N. Lafayette
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Hospital History

(Signed) G. C. Gladden, M. D. Coroner
19 (Address) 1436 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park
DATE OF BURIAL: 9/13 19 30

20 UNDERTAKER: Wilson Cook
ADDRESS: 1219 E. Pratt St

ec.—1-30—M. & T.—250 Bks.

E 60452

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 60452

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 6-9 (WARD)

2-FULL NAME Lorraine Krout

(a) RESIDENCE NO. 1726 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 20-1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Max Krout

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Sachs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. Lewis

(Address) 1439 E Balto St

15 Filed ....., 19.... H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1930, to Sept. 10, 1930, that I last saw h[er] alive on Sept. 10, 1930, and that death occurred, on the date stated above, at 9:30 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 2 ds

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 1726 E. Balto. Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isaac M. Bayliss, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Wash. Road

DATE OF BURIAL 9-11- 1930

20 UNDERTAKER Isaac Lewis, 1439 E Balto St

ADDRESS

Emma Lippy

...c.—2-29-28—L. F. S.—500 Bks.

E 60453

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60453

CERTIFICATE OF DEATH

REGISTERED NO. 24001

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 3008 Chesterfield AVE. (or) ST. 26-HD WARD)

2—FULL NAME Emma Lippy.

(a) RESIDENCE NO. 3008 Chesterfield AVE. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred 71 yrs. 7 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Lippy.

DATE OF BIRTH (month, day, and year) Jan. 21, 1859.

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71.	7.	18.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Charles Lippy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know.

Informant Wife Lippy.

(Address) 3008 Chesterfield Ave.

Filed ..... 19..

C. HAMPSON JONES, M.D. Registrar

11 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to Sept 9, 1930.

that I last saw her alive on Sept 9, 1930

and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

9/9/ 1930 (Address) 16xx Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Sept 11 1930

20 UNDERTAKER E. Howard Evans ADDRESS E. Fort Ave.

Cor.—10-10-29—A Co.—100 Blks.

E 60454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

182 E 60454

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found Floating in the Harbor at Pier 10 Canton 15-68 Ward

City of Baltimore: (No.)

2-FULL NAME William Wood 2216 Walbrook

(a) RESIDENCE NO. 2216 Walbrook St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian M Wood

6 DATE OF BIRTH (month, day, and year) Sept 1 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44		8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Checker
(b) General nature of industry, business, or establishment in which employed (or employer) on Boat
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) West Virginia

PARENTS

10 NAME OF FATHER Unknown Wood

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) W. Va

12 MAIDEN NAME OF MOTHER Nellie Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) W. Va.

14 Informant Miss J Fox
(Address) 1901 Fountain St

15 Filed ..... 19.. ..... Registrar

P 11 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to Find death on the day stated above.

The CAUSE OF DEATH was as follows:
Accidental Drowning

..... (duration) Sudden yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Henlon, M. D.

10. 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Fallows Cemetery — DATE OF BURIAL Sept 11 1930

20 UNDERTAKER H McCoulson — ADDRESS 2205 N Gay

sec.—2-29-28—L. F. S.—500 Bks.

E 60455

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 60455

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ~~217 Bond St~~ ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Dowdy

(a) RESIDENCE NO. 217 Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1912

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Arab

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Robert Dowdy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lillie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address)

15 Filed 1 1 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1930, to Sept 8, 1930, that I last saw him alive on Sept 8, 1930, and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH was as follows:

Cellulitis face

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-4-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. W. Peake, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: Sept 11 1930

20 UNDERTAKER: Edward Bryan — ADDRESS: 1691 Orleans St

E 60456

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60456

CERTIFICATE OF DEATH

REGISTERED NO. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Providence Hosp. ST. 64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Hawkins

(a) RESIDENCE NO. 320 N. Fun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vilor Hawkins

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Va

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Nathan Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Victor Burk
(Address) 820 N. Arms

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Reggie Hoffman, M. D.
Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery

DATE OF BURIAL Sept 11, 30

ADDRESS 1681 orleans st

20 UNDERTAKER Edward Bryan

spec.—1-12-23—M&T—500 Blks.

60457 E/60457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 E. Eager ST. 10-14 WARD)

2-FULL NAME Margaret M. Hogan

(a) RESIDENCE NO. 922 E. Eager ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur Hogan

7 DATE OF BIRTH (month, day, and year): July 24. 1862

AGE: Years 61 | Months 3 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Arthur McNamara

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Penney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

PARENTS

14 Informant (Son) (Address): George Hogan 922 E. Eager St.

15 Filed DEC 1 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 10, 1930, that I last saw her alive on Sept 9, 1930, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. ..... mos. one ds.

CONTRIBUTORY (Secondary): Uremic Coma (duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual ones

(Signed) Harp & Vaughan, M. D.

, 19 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Sept. 12, 1930

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E. Eager St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60458 60458 +146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital REGISTERED NO. 25-72

CITY OF BALTIMORE: (No. Eaton & Wilkins ave ST.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Virginia Sterner

(a) RESIDENCE NO. Catonsville Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr Willis Sterner

6 DATE OF BIRTH (month, day, and year) March 12 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	22	5	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Dwyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr Willis Sterner
(Address) Catonsville, Md.

15 Filed 11 1930 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12 . 1930 . to Sept. 11 . 1930 .

that I last saw h e alive on Sept 11 . 1930 .,

and that death occurred, on the date stated above, at 5 45 a. m. Standard time

The CAUSE OF DEATH* was as follows:

Puerperal Infection - followed by Septicemia & Lung Abscess

(duration) yrs. mos 45 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmar S Anderson M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamestown Cem. DATE OF BURIAL Sept. 13 1930

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

Spec.—6-9-19—P. P. Co.—1000 Bks.

MALESEWSKI

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60459

E 60459

CERTIFICATE OF DEATH.

MALESEWSKI

1131

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 3036 Boston St. 1-1 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Malezewski

(a) RESIDENCE. No. 3036 Boston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9 - 1930

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Malezewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Froney Posluszna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George Malezewski (Address) 3036 Boston St

15 Filed [redacted] H. HAMILTON JONES, M. D. Registrar

Per

1 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1930, to Sept 10, 1930, that I last saw her alive on Sept 8, 1930, and that death occurred, on the date stated above, at 5[10] A m.

The CAUSE OF DEATH* was as follows:

Cardio respiratory paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition - Diarrhoea 2 mos. 2 ds.

(duration) yrs.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. V. Chipt, M. D.

9-10, 1930 (Address) 3532 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Sept. 12 1930

20 UNDERTAKER Stephen J. Fialkowski Jr. ADDRESS 1002 S. Ren

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-001 E 60460

E 60460

REGISTERED NO. 47-53

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) NO. 1218 Carol Springs Ave ST. WARD

2-FULL NAME John Thomas Fitzpatrick

(a) RESIDENCE. NO. 1218 Carol Springs Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Fitzpatrick

6 DATE OF BIRTH (month, day, and year) Nov 1846

7 AGE: 84 Years | 10 Months | — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Farming

(c) Name of employer: C W Dennis

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Ignatius Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Worden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Edith Fitzpatrick
(Address) 1218 Carol Springs Ave

15 Filed SEP 13 1930 19. C. J. [illegible] JONES, M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1930, to Sept 11, 1930, that I last saw h in alive on Sept 9, 1930, and that death occurred, on the date stated above, at 4 7m. m.

The CAUSE OF DEATH* was as follows: Pneumonia & exhaustion

(duration) 1 yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Senile debility and

(duration) 5 yrs. 4 mos. 6 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Loss of vital signs

(Signed) C E Benson, M. D.

Sept 13, 1930 (Address) 6013 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pressgrove Cemetery

DATE OF BURIAL: Sept 13 1930

UNDERTAKER: Wm. E. Roach & Son

ADDRESS: Sparks, Md.

pec.—1-30—M. & T.—250 Bks.

Frances Beatty

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ E 60461

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Beatty

(a) RESIDENCE NO. 306 Labrot St Parkersburg W. Va WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced (a) HUSBAND of or (b) WIFE of Frederick

7 DATE OF BIRTH (month, day, and year) unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER James Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Charlotte Swan

13 BIRTHPLACE OF MOTHER (City, or town) (State or country) Ohio

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed OCT 1 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1930

17 I HEREBY CERTIFY, That I attended deceased from August 21, 1930, to Sept - 11, 1930, that I last saw h[illegible] alive on Sept - 11, 1930, and that death occurred, on the date stated above, at 8·32 a. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart Disease,

(duration) [illegible] yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? W. Virginia

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? examination heart & lungs

(Signed) John E Howard M. D.

7/10, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkersburg W Va

UNDERTAKER John O Mitchell & Son

DATE OF BURIAL Sept 11 1930

ADDRESS 1900 Eastern Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60462 — 90 E 60462

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Eutaw Place ST. 425 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Ann Byrd

(a) RESIDENCE NO. 1810 Eutaw Place WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Byrd

DATE OF BIRTH (month, day, and year) Jan 4 1845

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	8	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Balto md

10 NAME OF FATHER Wm F Fletcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Hester Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Fletcher L Byrd

(Address) 1810 Eutaw Place

Filed SEP 11 1930 — [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10/30.

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to Sept 10, 1930, that I last saw h[illegible] alive on Sept 10, 1930 and that death occurred, on the date stated above, at 1 0. m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Samuel [illegible] Lewis, M. D.

19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Sept 12 19 30.

20 UNDERTAKER John O Mitchell & Son

ADDRESS 1110 Eutaw place

(Rec.—8-16-29—L. F. S.—100 Bks.

60463

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 60463

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1606 Johns St. (WARD) 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan Jane Traband

(a) RESIDENCE NO. 1606 Johns St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo W. Traband

DATE OF BIRTH (month, day, and year): Oct 13 1846

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	9	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: John Hoyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Eliza Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Kate F. Howard

(Address) 1606 Johns St.

15 Filed SEP 12 1930 CHARLES C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 10. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1930, to Sept. 9, 1930, that I last saw her alive on Sept 9, 1930, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar V. Sandrock M. D.

Sept 11, 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: Sept 12 1930

20 UNDERTAKER: John O Mitchell & Son

ADDRESS: 1911 Eastern

Cor.—10-10-29—A Co.—100 Bks.

E 60464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 60464

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bald. City Hospital St., 8-26 Ward)

2-FULL NAME William Williams

(a) RESIDENCE NO. 847 W Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~years~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Williams

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Unknown William

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Laura unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant Gertrude Williams
(Address) 917 W Saratoga

15 Filed ..... C. [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and, from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

Sept 10 1930 (Address) 1002 Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Sept 11, 1930

20 UNDERTAKER Mrs Kate R Williams

ADDRESS 322 E Lanvale

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60465

CERTIFICATE OF DEATH.

161-661

E 60465

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2012 Cold Spring St. (WARD) 27-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nickum

(a) RESIDENCE. No. 2012 Cold Spring St., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 10. 1930

7 AGE Years Months Days If LESS than 1 day 11 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 2012 Cold Spring Ave
(State or country) Balto.

PARENTS

10 NAME OF FATHER Willie Butler

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mazie Nickum

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant
(Address)

15 Filed 1 1 1930, 19 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept 10, 1930

that I last saw him alive on Sept 10, 1930,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Premature Infant
about 7 mo

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James J. Ashurst, M. D.

9-11-30 (Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 10 1930

20 UNDERTAKER Commissioner Health

ADDRESS

Pat. Wm. E. Woodall

Dec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60466

CERTIFICATE OF DEATH.

E 60466

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Jenkins Memorial Hosp ST. 12-50 (WARD)

2-FULL NAME Mary Josephine Ferguson

(a) RESIDENCE NO. 775 E. 25th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE: Years 87; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm S Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Jenkins Memorial Hospital

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 19 30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 30, to Sept 10, 19 30, that I last saw her alive on Sept 10, 19 30, and that death occurred, on the date stated above, at 1 45 p. m. E. S. T.

The CAUSE OF DEATH* was as follows:

Chronic arteriosclerosis

C. V. R disease

General debility.

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? 4 hours

Did an operation precede death? No Date of \

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Sign.

(Signed) Chas F. Mitchell M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Sept 12 19 30

20 UNDERTAKER: Johnson & Son

ADDRESS: 3405 Eastern

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

187 ✓ 001 E 60467

CERTIFICATE OF DEATH

E 60467

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 27-41 WARD

2-FULL NAME William Baker

(a) RESIDENCE No. 4004 Woodley Road ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25		5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coil Winder
(b) General nature of industry, business, or establishment in which employed (or employer) Monitor
(c) Name of employer Controller Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. B. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Gesford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Martha Betz

(Address) 612 N. Collington Ave

15 Filed 1-1930 C. HAMPSON JONES, M. D. Registrar

By ADK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull. Accidental Death. Struck by Elevator

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At work

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Gilbert Coroner, M. D.

9/11, 1930 (Address) 2730 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Sept 13 1930

20 UNDERTAKER Edmondson Bros

ADDRESS 1361 5 Pulaski Hwy

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60468

CERTIFICATE OF DEATH

15-66 31 E 60468

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2215 Mt Holly St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Harry Bond

(a) RESIDENCE NO. 2215 Mt. Holly St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nettie Lyles Bond

6 DATE OF BIRTH (month, day, and year) Sept. 6, 1879

7 AGE 51 Years 0 Months 4 Days IF LESS than 1 day ____ hrs. or ____ min..

51

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md. Tobacco Growers Assoc.

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Brooke Bond

11 BIRTHPLACE OF FATHER (City or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Eliza Sauger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Wife

(Address) Same

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1928, to Sept 10, 1930, that I last saw him alive on Sept 10, 1930, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(doration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Dysentery

(doration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteria

(Signed) Thos. B. Turner, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mutual, Calvert Co. Data of Burial 9/12 1930

20 UNDERTAKER Whitmore Cook ADDRESS 1216 Park

Very Important. See instructions on back of this sheet.

pec.—1-30—M. & T.—250 Bks

E 60469 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60469

113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 20-64 WARD)

2-FULL NAME Earl Barbour

(a) RESIDENCE NO. 2644 Delaney St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) June 4th 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm Clarence Barbour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Myrtle Margaret Petzinger

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Wm C. Barbour (Address) 2644 Delaney St

15 Filed DEC 2 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11/30

17 I HEREBY CERTIFY, That I attended deceased from 9-8-, 1930, to 9-11, 1930, that I last saw him alive on 9-11, 1930, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Lateral (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs, Symptoms, Lab work.

(Signed) J. H. Bloomberg, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 12/1/ 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

spec.—1-12-23—M&T—500 Bks.

E 60470 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 60470

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2344 (ST.) Sydney (WARD) 25-32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice V. Kemp

(a) RESIDENCE NO. 2344 (ST.) Sydney Ave (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Kemp

6 DATE OF BIRTH (month, day, and year): Oct. 5th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	58	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Co.

PARENTS

10 NAME OF FATHER: Solomon Shaff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co.

12 MAIDEN NAME OF MOTHER: Sarah Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co.

14 Informant: Frank Kemp

(Address) 2344 Sydney Ave

Filed 12 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/11/1930

17 I HEREBY CERTIFY, That I attended deceased from 6/30, 1930, to 9/12, 1930,

that I last saw her alive on 9/12, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac deficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic myocarditis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical exam.

(Signed) J. W. Upton, M. D.

(Address) 2237 Annapolis Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 9/13/1930

20 UNDERTAKER: Wm. Cook

ADDRESS: 1217 St Paul St

Cor.—12-9-25—A Co.—200 Bks.

E 60471

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60471

188-03

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 6-10 Ward)

2-FULL NAME Franklin E Cof

(a) RESIDENCE NO. 2636 E Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth J Cof

6 DATE OF BIRTH (month, day, and year) Sept 5 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	67		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town)

(State or country) Fairmount Md

PARENTS

10 NAME OF FATHER Edward C Cof

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Fairmount Md

12 MAIDEN NAME OF MOTHER Sarah W Leach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Fairmount Md

14 Informant Wm Benj F Cof

(Address) 2636 E Balto St

Filed SEP 12 1930 C. HAMPSON JONES M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows

Struck & knocked down by motor Auto Aug 20

(Antecedent) yrs. mos. ds.

Cond. Contrib - Fract Mult. Ribs - Colles fract

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) H J France M. D.

9/11 1930 (Address) 3934 Wm Aldern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmount Md Via Crisfield & P. R.R. Date of Burial Sept 12 1930

UNDERTAKER John F Denny ADDRESS 715 Light St

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60472 90 E 60472

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals ST. 16-23 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.)

2-FULL NAME: Louis Gross

(a) RESIDENCE NO. 1135 Harlem Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Lucy

7 DATE OF BIRTH (month, day, and year): Jan. 3, 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 640

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Queen Anne Co. Md.

PARENTS

10 NAME OF FATHER: William

11 BIRTHPLACE OF FATHER (city or town) (State or country): da

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Records of Balto. City Hosp.

Filed D 1-2 1930

H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-9-30

17 I HEREBY CERTIFY, That I attended deceased from 9-6-30, 19.. to 9-9-30, 19..

that I last saw him alive on 9-9-30, 19..

and that death occurred, on the date stated above, at 4:45 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic + benign

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jos. Shwartz Jr, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Sept 12, 1930

20 UNDERTAKER: John N. Troden

ADDRESS 1027 Hanover

pec.—1-30—M. & T.—250 Bks.

E 60473

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60473

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1872 linden ave St. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Homer S. McDowell

(a) RESIDENCE NO. 1872 linden ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Florence McDowell

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Florence McDowell (Address) 1872 Linden ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to Sept 11, 1930,

that I last saw h.. alive on Sept 11th, 1930,

and that death occurred, on the date stated above, at 7:25 P. m. D.S.T.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) J. B. Winterhalter M. D.

9/11, 1930 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Western Cem —

DATE OF BURIAL 9-12 1930

ADDRESS 516 Park ave.

20 UNDERTAKER Daniel Easton

pec.—1-30—M. & T.—250 Bks.

E 60474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60474

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 Seldon Ave ST., 13 WARD)

2-FULL NAME Anna M. Hopkins

(a) RESIDENCE NO. 1324 Seldon Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of John C. Hopkins

7 DATE OF BIRTH (month, day, and year) April 25-1891

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	4	15	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Doering

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John C. Hopkins

(Address) 1324 Seldon Ave

15 Filed SEP 12 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10-1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Sept 10, 1930, that I last saw h[illegible] alive on Sept 10, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Richardson M. D.

9/11/30 (Address) 117 W. 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest

DATE OF BURIAL Sept. 13 1930

20 UNDERTAKER Horace M. Rouse

ADDRESS 3131 Falls Road

Cor.—12-9-35—A Co.—200 Bks.

Mackenroth

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60475

CERTIFICATE OF DEATH.

117 E 60475

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's 23333 St. _____ Ward)

2-FULL NAME Adolph C. Mackenroth.

(a) RESIDENCE NO. 1343 S. Charles St. Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 42 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth K. Mackenroth.

6 DATE OF BIRTH (month, day, and year) July 7, 1864.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66,	2,	4.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Owner.

9 BIRTHPLACE (city or town) Germany. 9/12/30

(State or country)

10 NAME OF FATHER William Mackenroth.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

PARENTS

14 Informant Elizabeth K. Mackenroth. (Wife)

(Address) 1343 S. Charles St.

Filed SEP 12 1930, 19___ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 11, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Peritonitis - Ruptured Appendix

(nooperation)

(durntion) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(durntion) ___ yrs. ___ mos. ___ ds.

(Signed) H. H. Bates M. D.

(Coroner)

(Address) 408 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Pk. Cem Date of Burial Sept 13, 1930

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Fayette

SEP 12 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60476 | 13E 60476

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 707 N. Hanover ST. 22-30 WARD)

2-FULL NAME Thomas C Taylor

(a) RESIDENCE NO. 707 N. Hanover ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/12/30

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Albert Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Elizabeth Sanders
(Address) 707 N. Hanover St.

15 Filed SEP 12 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10/30

17 I HEREBY CERTIFY, That I attended deceased from 9/8/30, to 9/10/30.

that I last saw him alive on 9/10/30.

and that death occurred, on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
Gastritis —
(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Overfeeding
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Bartley M. D.

9/12/30 (Address) 708 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 12 1930

20 UNDERTAKER C. W. Brown & Son ADDRESS 101 W. Mulberry St.

pec.—1-30—M. & T.—250 Bks.

Dr Snyder Eastern Ave & Potomac St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60477

129 E 60477

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 339 S. Ellwood Ave ST. E-W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Mahr

(a) RESIDENCE NO. 339 S. Ellwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, ~~or divorced~~ HUSBAND of or) WIFE of: Peter Paul Mahr

6b DATE OF BIRTH (month, day, and year): Apr 18th 1852

7 AGE: Years 78 | Months 4 | Days 13 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Godfried Tews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Elizabeth Horner

(Address) 339 S. Ellwood Ave

15 Filed ....., 19.... Registrar

1 21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/11/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Sept 11, 1930, that I last saw h alive on Sept 10, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

acute Nephritis

(duration) ....yrs. mos 5 ds.

CONTRIBUTORY (Secondary) chronic Nephritis

(duration) ....yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C.A. Reuschlein M. D.

9/12 19 30 (Address) 2439 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: 9/15/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 S. Paul St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60473

E 60473

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 716 Ajax St. St. 10-11th Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Waters

(a) RESIDENCE NO. 716 Ajax St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis Waters

6 DATE OF BIRTH (month, day, and year): July 18-1888

7 AGE — Years: 42 Months: 1 Days: 22 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: John Waters

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Sara Buchanan

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Francis Waters

(Address) 716 Ajax St.

15 Filed: DEC 12 1930, 19..

Registrar: JOHN JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Cardio-Vascular Disease

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Kalen M. D.

(Coroner)

12/11/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery Date of Burial Dec. 13 1930

20 UNDERTAKER: Elmer H. Johnson ADDRESS 46 N. Carolina

Very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

24056 3

E 60479

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

44 E 60479

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Michael Norton

(a) RESIDENCE NO. 620 E-Biddle ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 61 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder

(b) General nature of industry, business, or establishment in which employed (or employer): 0/6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Dennis Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bryant Weddington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed 1 2 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): ~~Sept~~ Sept 11, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept 11, 1930, that I last saw him alive on Sept 11, 1930, and that death occurred, on the date stated above, at 12 05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Gastric hemorrhage

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): chronic alcoholism (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? place of residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Caroline C. Bedell, M. D.

9/11, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Sept 15 1930

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Fremont Ave

1-30—M. & T.—100 B—50L

E 60480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

198 E 60480

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Poor Hospital ST. 16-22 WARD)

2-FULL NAME James Smith

(a) RESIDENCE NO. 107 Canton ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7-14

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Walter Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia Lacy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Julia Smith

(Address) 107 Canton

15 Filed SEP 12 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Stab Wound of Chest
Pocket Knife

(duration) Ten to 15 hrs yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lafayette Market

Did an operation precede death? Yes Date of Sept 6-30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Wades Coroner, M. D.

, 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 13 30

ADDRESS

20 UNDERTAKER Wm. H. Case & Son 1100 Mosher

P 12 1930

1-30—M. & T.—100 B—50L

E 60481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 60481

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2105 E. Fairmount ST. 5-9 (WARD)

2-FULL NAME Pattie Lawrence

(a) RESIDENCE NO 317 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Lawrence

6 DATE OF BIRTH (month, day, and year) Apr 1/1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 6/10
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm. Bland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Broadway 9/11/50

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant George Bryan

(Address) 1631 Orleans St

15 Filed ..... 192 C. HAYDEN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 9/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardio- Vascular Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D. Coroner

19 (Address) 502 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Suffolk Va

DATE OF BURIAL Sept 30

UNDERTAKER Edward Bryan

ADDRESS 1681 Orleans St

Spec. 7-17-26—A Co. 200 Bks.

Merritt

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

E 60482

CERTIFICATE OF DEATH

E 60482

REGISTERED NO.

15-63

1-PLACE OF DEATH

City of BALTIMORE: (No. 3835 Boarman Ave St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Leonard Merritt

(a) RESIDENCE NO. 3835 Boarman Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8-1929

7 AGE Years 1 Months 5 Days 4 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Aaron Merritt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sylvia Greenfield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimd.

14 Informant S. Merritt

(Address) 3835 Boarman Ave

15 Filed SEP 12 1930 C. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9th, 1930 to Sept 12 1930

that I last saw h alive on Sept 12 1930

and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological

(Signed) Harry J. Lemkin M. D.

(Address) 613-615 N. Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

Date of Burial Sept 15 19 30

20 UNDERTAKER H. Furnier & Bro

ADDRESS 112 E Balto St

very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60483 — 100-09 E 60483

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1335 Carroll ST. 21-29 WARD)

2-FULL NAME Bernice Ford Carroll

(a) RESIDENCE NO. 1335 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 1930

7 AGE — Years | 7 Months | 22 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Lester Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Bertie Coursen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Lester Ford 1335 Carroll

15 Filed 12 1930 19 E. HAMPTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11/30

17 I HEREBY CERTIFY, That I attended deceased from 9/10, 1930, to 9/11, 1930, that I last saw h[illegible] alive on 9/11, 1930, and that death occurred, on the date stated above, at 1 2-10 a.m.

The CAUSE OF DEATH* was as follows:

acute Bronchopneumonia

Primary

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? none.

(Signed) Wm Swanson, M. D.

9/12/30 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL 9/12 1930

20 UNDERTAKER: Walter B. Spriggs

ADDRESS 1394 W Hamburg St.

Spec.—1-10-21—MAT—1500 Blks.

E 60484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60484

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 232 N. Stilton ST. 20-10 WARD)

2-FULL NAME Charlotte L. Hellary

(a) RESIDENCE NO. 232 N. Stilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William L Hellary

6 DATE OF BIRTH (month, day, and year): — 1868

7 AGE: Years 32 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Geo L Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine Biddison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Geo W Pennington 3104 Seaview Ave

15 Filed 2 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1930, to Sept 11, 1930, that I last saw her alive on Sept 11, 1930, and that death occurred, on the date stated above, at 12.45 p m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm E Brown, M. D.

9/11, 1930 (Address) 198 Griffeon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemy DATE OF BURIAL 9/12 1930

20 UNDERTAKER: Edward Foulsom ADDRESS Wash Blvd

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 60485

REGISTERED NO. E 60485

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2115 N. Fayette ST., (WARD) 20-27

2—FULL NAME Carter Braxton Gutridge

(a) RESIDENCE NO. 2115 N. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 3" 1915

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	6	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Joseph C. Gutridge

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Lilly N. Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Joseph C. Gutridge

(Address) 2115 N. Fayette St.

15 Filed 12 1930 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10" 1930

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to Sept 10, 1930, that I last saw h in alive on Sept 9, 1930 and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

CONTRIBUTORY (Secondary) Bacterial endocarditis (duration) yrs. 6 mos. ds.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What lest confirmed diagnosis? none

(Signed) F. L Kerlucke, M. D.

9/10, 1930 (Address) Rexton.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cemetery

DATE OF BURIAL Sept 13" 1930

20 UNDERTAKER Joseph Cook

ADDRESS 1003 N. Eutaw St.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60486

49 E 60486

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospital

CITY OF BALTIMORE: (NO. 4-30 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt. L. Makinson

(a) RESIDENCE 611 N. Bolton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ida B. Makinson

6 DATE OF BIRTH (month, day, and year) Mch 20 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Stone Mason

(c) Name of employer ?

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Makinson

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Lina ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records (Address) Baltimore City Hosp.

15 Filed SEP 12 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11-30

17 I HEREBY CERTIFY, That I attended deceased from 4-7-, 1930, to 9-11-, 1930, that I last saw h~~im~~ alive on 9-11-1930, and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Hypernephroma of left kidney with metastasis to spine & ribs (duration) unknown

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Fred M. Duckwall M. D.

9/11/30 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Sept. 13, 30

20 UNDERTAKER Leopold Cook

ADDRESS 1003 West Baltimore St.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60487

REGISTERED NO. E 60487

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. U. G. Hospital ST. 9-47 (WARD)

2-FULL NAME Lillian C. Wade.

(a) RESIDENCE NO. 760 Franklin Town Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ingram Wade

6 DATE OF BIRTH (month, day, and year) May 10-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. Beatty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Frances Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo. Beatty

(Address) 3507 Glenmore

15 FILED DEC 12 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rheumatic Fever

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Endocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 760 Franklin Rd

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Glade, M. D. Coroner

, 19 (Address) 1730 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL Sept 12 1930

20 UNDERTAKER L J Bush

ADDRESS 640 S Bethel

Cor.—10-10-29—A Co.—100 Bks.

E 60488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. U. S. Marine Hospital St. 7-4 Ward)

2-FULL NAME Harold Loraas,

(a) RESIDENCE NO. 1605 Fleet Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 16, 1895

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
34	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer SS Wm. G. Warden

9 BIRTHPLACE (city or town)
(State or country) Norway

PARENTS

10 NAME OF FATHER Marrus Loraas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Norway

12 MAIDEN NAME OF MOTHER Hanna ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Norway

14 Informant U. S. Marine Hospital Records
(Address) Baltimore, Maryland

15 [illegible] 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:
Fract Co. R. Mastoid -
Arteio C - 5-6 Cerv. vertebrae
fell in Cow in truck pushed underneath off of truck while it was moving
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Provident Bath Co

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

9/12 1930 (Address) 1932 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden — DATE OF BURIAL Sept. 6, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc. — ADDRESS 125 E. North Ave.

E. Leroy Stiffler, Inc.

Important. See instructions on back of certificate.

3 1930

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60489

CERTIFICATE OF DEATH

E 60489

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N. Stricker ST. 14-28 WARD)

2-FULL NAME Catherine Williams

(a) RESIDENCE NO. 224 N. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	10	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: H W
(b) General nature of industry, business, or establishment in which employed (or employer): 0
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER George Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Downing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Jno. Williams

(Address) 224 N. Stricker

15 Filed 1-3 1930 192 ... Registrar HAMPSON JOHNSON

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. H. Brooke M. D.
Coroner

9/11 1930 (Address) 3601 Third Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnson Conn — DATE OF BURIAL: Sept 15 1930

20 UNDERTAKER: Floyd A Lively — ADDRESS: 892 N. Mount St

Spec.—1-12-23—M&T—500 Bks.

Dr Shannon 700 N Fulton Ave

E 60490

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60490

CERTIFICATE OF DEATH.

REGISTERED NO. 124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 N. Fulton Ave ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine L. Walter

(a) RESIDENCE NO. 229 N. Fulton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Walter

6 DATE OF BIRTH (month, day, and year) Aug 13-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	71	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Stumbo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Wilt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alice M. Walter (Address) 229 N. Fulton Ave

15 Filed SEP 13 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1930

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to Sept 12, 1930, that I last saw her alive on Sept 11, 1930, and that death occurred, on the date stated above, at 8 30 A.m.

The CAUSE OF DEATH* was as follows:

Chr. Pancreatic Congestion of Liver

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) ? yrs. mns. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo E. Shannon, M. D.

9/12, 1930 (Address) 700 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 9/15/1930

20 UNDERTAKER Wm Cook

ADDRESS 127 S Paul St

P 13 1930

Spec.—1-30—M. & T.—250 Bks. Dr Athey Patterson Pk Ave & Lombard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60491 91-002 E 60491

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 S. Clinton St. 76-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia Ottan

(a) RESIDENCE NO. 305 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ or) WIFE of Henry Ottan

6 DATE OF BIRTH (month, day, and year) Mar 4th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Mills

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla Wingate

13 BIRTHPLACE OF MOTHER (city or town) Easton (State or country) Md

14 Informant Ellen O. Meehan

(Address) 305 S. Clinton St

15 Filed SEP 13 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to Sept 11, 1930, that I last saw h[illegible] alive on Sept 11, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 4 mos 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb V. Athey, M. D.

Sept 12, 1930 (Address) 100 S. Patterson Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 9/13/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

E 60492 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60492

CERTIFICATE OF DEATH. X 32

REGISTERED NO. 4-30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Jackson

(a) RESIDENCE NO. Owings Mills, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Owings Mills Md

(State or country)

PARENTS

10 NAME OF FATHER Isaac Jackson

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Maxwell

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Isaac Jackson

(Address) Owings Mills Md

Filed 3 1930 19 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-8, 1930, to 9-12, 1930,

that I last saw her alive on 9-12, 1930,

and that death occurred, on the date stated above, at 7.45 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 5 hrs ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History, Signs, Sympt + Lab findings

(Signed) Lt H Hasenbaker, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

Cerebral Abscess

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Thomas. Md

DATE OF BURIAL 9/15/30

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Saul St

Spec.—1-30—M. & T.—250 Bks.

E 60493

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60493

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH Baltimore City Hospital ST. 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.)

2-FULL NAME Josyh Dawn ST., WARD

(If non-resident give city or town and State)

(a) RESIDENCE NO. 1228 Williams

(Usual place of abode)

Length of residence in city or town where death occurred 5-6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-10-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) ? 050

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Dawn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Gilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records Baltimore City Hosp.

(Address)

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-12-30

17 I HEREBY CERTIFY, That I attended deceased from 6-21-, 1930, to 9-12, 1930, that I last saw h alive on 9-12, 1930, and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cardiac end of stomach with local & metastasis

(duration) months ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 6-30-30

Was there an autopsy? yes

What test confirmed diagnosis autopsy

(Signed) Fred M. Rhebstall M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross 9-16 1930

DATE OF BURIAL

20 UNDERTAKER Earl B Hark ADDRESS 115 E Mont St

HAMPSON JONES

1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60494

CERTIFICATE OF DEATH

29 E 60494

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1519 Shields ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alethia Johnson

(a) RESIDENCE NO. 1519 Shields ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2 Feb. 1867

7 AGE: Years 63 | Months 7 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Servic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Calvert Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Amelia Hands

(Address) 1623 Vermont St

15 Filed 1930, C. HAMPSON JONES, M. D.

Bur

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1930 to Sept 11, 1930 that I last saw h alive on Sept 11, 1930 and that death occurred, on the date stated above, at 10:15 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Phronic Nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) John H Fotopoulos, M. D.

9/11, 1930 (Address) 1012 N. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Sept 13 1930

20 UNDERTAKER: Hanna & Wright — ADDRESS: 700 N Eutaw

Spec.—1-30—M. & T.—250 Bks

E 60495 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60495

CERTIFICATE OF DEATH. REGISTERED NO. 74-69

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (NO. 745 W Lanvale ST. WARD 16)

2-FULL NAME Frank Cockrell

(a) RESIDENCE NO. 745 W Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1888

7 AGE: Years 42 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Longshoreman

(b) General nature of industry, business, or establishment in which employed (or employer) Dock

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm. Johnson (Address) 2611 Druid Hill

15 Filed ..... 19 ..... Registrar

13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 '30

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Sept 10, 1930, that I last saw him alive on Sept 10, 1930, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. K. Causey M. D.

, 19 (Address) 763 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 9/13/1930

20 UNDERTAKER Mrs. Geo. H. Kolla

ADDRESS 1631 Druid Hill Ave

Spec.—1-30—M. & T.—250 Bks.

E 60496 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60496

CERTIFICATE OF DEATH.

REGISTERED NO. 16-082

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. President Hospital ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Jones

(a) RESIDENCE NO. 1804 Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 10 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	9		

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Balto

PARENTS

10 NAME OF FATHER Gardner Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Wilhelmina Ireland

(Address) 1804 Preston ST. (HARRISON JONES)

15 Filed ....., 19 ..... Registrar

12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Sept 10, 1930, that I last saw h.. alive on Sept 10, 1930, and that death occurred, on the date stated above, at 10:25 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 13 1930

20 UNDERTAKER Virginia G. Brooks — ADDRESS 1463 N. Carey

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60497 E 60497 88

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 321 N. Carroll St. (ST.) 18-16 (WARD)

2-FULL NAME Dena Harris

(a) RESIDENCE NO. 321 N Carrollton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	M

5a If married, widowed, or divorced (HUSBAND of or) WIFE OF Frederick H Harris

6 DATE OF BIRTH (month, day, and year) July 8 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER William Corbett

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) N. Ca

12 MAIDEN NAME OF MOTHER Ria Godmans

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant Frederick H. Harris

(Address) 321 N. Carrollton

15 [illegible] 19 ..... HAMPSON JONES Registrar

1 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11-30

17 I HEREBY CERTIFY, That I attended deceased from 9-8 ..... 19 30 ..... to 9-11- ..... 19 30 .....

that I last saw h~~e~~ alive on 9-9- 19 30

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Acute Bacterial Endocarditis

Duration ..... yrs. ..... mos 1 6 ds.

CONTRIBUTORY (Secondary) Acute Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. [illegible] Carlson M. D.

9/11/1930 (Address) Coon Allegheny

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Sept 15 1930

20 UNDERTAKER Wm H. Chase & Son

ADDRESS 1400 Mosher

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 60498

E 60498

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1709 Eastern Ave ST. 12-4 (WARD)

2—FULL NAME Minna Rader

(a) RESIDENCE NO. 1709 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Herman Rader

6 DATE OF BIRTH (month, day, and year): March 4, 1852

7 AGE: Years 78 | Months 6 | Days 8 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Valentine Leopold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Stundmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs. Anna Greer

(Address) 1709 Eastern Ave

15 Filed ..... 19 ..... Registrar

THOMPSON JONES M.

1 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 12 30

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1930, to Sept 12, 1930.

that I last saw her alive on Sept 12, 1930

and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asthma

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. Heller M. D.

(Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL 19

20 UNDERTAKER: Louis J Deemann — ADDRESS 32 S. Broadway

Rec. 2-29-28—L. F. S.—500 Bks.

E 60499 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60499

CERTIFICATE OF DEATH

REGISTERED NO. 15-58

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. General Hospital ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Hanon

(a) RESIDENCE NO. 25 86 Boarman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank J. Hanan

6 DATE OF BIRTH (month, day, and year): Sept 12, 1900

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
29	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Chicago, Ill

PARENTS

10 NAME OF FATHER: George Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chicago, Ill

12 MAIDEN NAME OF MOTHER: Emma Stackhouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Chicago, Ill

14 Informant: Hospital records.

(Address): HANSON JONES

15 Filed SEP 13 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/10/30

17 I HEREBY CERTIFY, That I attended deceased from 9-10-, 1930, to 9-10, 1930

that I last saw her alive on 9-10 1930

and that death occurred, on the date stated above, at 7 55 P m.

The CAUSE OF DEATH* was as follows: Strangulated Femoral Hernia (Rt.)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 9-10-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert X. Chenoweth, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Sept 13, 1930

20 UNDERTAKER: John A. Moran

ADDRESS: 300 E. Baltimore St.

E 60500

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60500

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 3-4 ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Jones

(a) RESIDENCE NO. 1506 Gough ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widowed

6a If married, widowed, or divorced
HUSBAND of
or) WIFE of Charles Jones.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Washington
(State or country) D. C.

PARENTS

10 NAME OF FATHER Geo. Savey

11 BIRTHPLACE OF FATHER (city or town) Unk
(State or country) D. C.

12 MAIDEN NAME OF MOTHER Brighton Lane

13 BIRTHPLACE OF MOTHER (city or town) Unk.
(State or country) D. C.

14 Informant .....
(Address) Baltimore City Hosp.

Filed DEC 13 1930 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-9-30

17 I HEREBY CERTIFY, That I attended deceased from 8-11-, 1930, to 9-9-, 1930.

that I last saw h[illegible]ive on 9-9-, 1930,

and that death occurred, on the date stated above, at 7 50 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) Unknown

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 8-25-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Fred M. Dunkenwald M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Park Cem

DATE OF BURIAL Dec 13 1930.

UNDERTAKER Wendell Dargel

ADDRESS 300 N Eden

E 60501

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60501

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 W. North Ave. ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael J. Finnerty

(a) RESIDENCE NO. 1933 W. North Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Gregory Finnerty

6 DATE OF BIRTH (month, day, and year) July - 1870.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Finnerty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Fitzmaurice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas Finnerty

(Address) 1933 W. North Ave

15 9/13 1930 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 1930 to Sept 12 1930, 19..., 19...

that I last saw him alive on Sept 12 1930

and that death occurred, on the date stated above, at 11 A.M.

THE CAUSE OF DEATH* was as follows: Carcinoma (Gastric)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Thos Hennessy) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? W. C. Hunt, M. D.

(Signed)

(Address) 14 W. Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 9/15 1930

ADDRESS

20 UNDERTAKER Martin Fahey & Sons

1827 W. North Ave

Spec.—1-30—M. & T.—250 Blks

E 60502 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60502

CERTIFICATE OF DEATH.

X 146

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH University Hospital
CITY OF BALTIMORE: (No.) 4 30 ST., (WARD)

2. FULL NAME Mrs. Ada Elliott
(a) RESIDENCE NO. 24 Fleet ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married
5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard Elliott
6 DATE OF BIRTH (month, day, and year): Aug 11 1901
7 AGE: Years 29; Months 1; Days 12; If LESS than 1 day, ... hrs. or ... min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country): Ireland
PARENTS
10 NAME OF FATHER: Joseph Conlter
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Hurley
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland
14 Informant: Mr Richard Elliott
(Address) 24 E Cagsley R
15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/12/30
17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1930, to Sept 12, 1930, that I last saw h[illegible] alive on Sept 12, 1930, and that death occurred, on the date stated above, at 4 45 Am.
The CAUSE OF DEATH* was as follows:
Abortion - self induced (duration) ... yrs. ... mos. 6 da.
CONTRIBUTORY (Secondary): Septicemia (duration) ... yrs. ... mos. 8 da.
18 Where was disease contracted if not at place of death? at home
Did an operation precede death? yes Date of Sept 6, 1930
Was there an autopsy? yes
What test confirmed diagnosis? Blood culture
(Signed) W. H. Varney, M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn
DATE OF BURIAL: Sept 15, 1930
20 UNDERTAKER: John F Denny
ADDRESS: 745 Light St

Argue Fuller & Co off

13 1930

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60503 E 60503

CERTIFICATE OF DEATH.

REGISTERED NO. 159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1126 Ensor St. (St.) 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. McGuire

(a) RESIDENCE NO. 1126 Ensor St. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of — Child

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles L. McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret B. Fennessy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Charles L. McGuire
(Address) 1126 Ensor St

15 Filed SEP 13 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 19 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1930, to Sept 12, 1930, that I last saw him alive on Sept 12, 1930, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Acute dilitation of heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M.D.

19 30 (Address) 2458 Hanover Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Sept 16 1930

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E Eager St.

FROM IN VERY IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60504

CERTIFICATE OF DEATH

1803 E 60504

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins St. 10-9 Ward)

2-FULL NAME James Smith

(a) RESIDENCE NO. 10 N. Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	B	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	14		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jas. Smith

11 BIRTHPLACE OF FATHER (city or town) St Marys Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Symmonds

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co Md
(State or country)

14 Informant James Smith Fa
(Address) 10 N. Caroline St

15 Filed ..... 19.. Registrar

13 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Struck & knocked down by moving auto

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract Rib R. Multiple

R. Femur Fracture of R. upper leg (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Eden & Monument

Did an operation precede death? no Date of

Was there an autopsy? Yes Pathological

What test confirmed diagnosis?

(Signed) L. F. Frame, M. D.

9/12 1930 (Address) 1334 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 9-14 1930

20 UNDERTAKER Byron & Wright

ADDRESS 1218 N. Eden St

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION very OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Bks

E 60505

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60505

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 9-18 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Hawkins

(a) RESIDENCE NO. 1407 Harford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Corah

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59 60	60	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk man

(b) General nature of industry, business, or establishment in which employed (or employer) 056

(c) Name of employer himself

9 BIRTHPLACE (city or town) Ann Arundle Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Isaiah Hawkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Oden

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed ... 19 ... C. MAXWELL JONES, M.D. Registrar

L3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10-30

17 I HEREBY CERTIFY, That I attended deceased from 8-4-30, 19 ..., to 9-10-30, 19 ..., that I last saw h. ill alive on 9-10-30, 19 ..., and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic + acute

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of ...

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Shmold Jr, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cem

DATE OF BURIAL 9-14 19 30

20 UNDERTAKER Byron Wright 1218 Nc & Aders 4/8+

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60506

CERTIFICATE OF DEATH

90 E 60506

REGISTERED NO. 16243

1—PLACE OF DEATH 1025 or Carey St

CITY OF BALTIMORE: (No.) ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mitchell Dandridge

(a) RESIDENCE NO. 1025 N. Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Dandridge

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 + 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Byrd Dandridge

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Carrie Brakenber
(Address) 1025 Carey st

15 Filed SEP 13 1930, 19 C. MAURICE JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10/30

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930 to Sept 10, 1930

that I last saw h[illegible] alive on Sept 10, 1930

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Degeneration

(duration) yrs. 6 mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/10, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Sept 13 1930

20 UNDERTAKER Thos. E. Gibson — ADDRESS 1303 Pennsylvania Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60507

CERTIFICATE OF DEATH

122 V-002

E 60507

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 S. Bouldin ST. 26-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ERNEST HENRY MEYERS

(a) RESIDENCE NO. 705 S. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Meyers

6 DATE OF BIRTH (month, day, and year) Nov. 25. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 62

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 5 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Augusta Meyers

(Address) 705 S. Bouldin St.

15 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1930, to Sept. 11, 1930, that I last saw him alive on Sept. 10, 1930 and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows: Chr. Bright's Disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry E. Wilson, M. D.

, 19 (Address) 137 N. Biddle St. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Sept. 14 1930

20 UNDERTAKER Henry Sands & Sons, Inc.

ADDRESS Baltimore St & Broadway.

Spec.—1-30—M. & T.—250 Bks.

240410 E 60508

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60508

CERTIFICATE OF DEATH.

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-9 WARD)

2-FULL NAME Wallace J. Jordan

(a) RESIDENCE NO. Norfolk Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Bessie

6 DATE OF BIRTH (month, day, and year) Sept-24-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Manufctr

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car

12 MAIDEN NAME OF MOTHER Alice Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL Records (Address) THOMPSON JONES M.D.

15 Filed 1930 19 RRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-12-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept-5, 1930, to Sept 12, 1930, that I last saw him alive on Sept-12, 1930, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

1. Caries Dorsalis
2. fracture of rt. humerus

(duration) (1) 3 yrs. (2) 1 mos 7 ds.

CONTRIBUTORY (Secondary) (1) Thrombosis axillary vein (2) pulmonary infarct (right)

(duration) (1) yrs. mos. (2) 9 ds. (2) 1

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) John Howard M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk, Va DATE OF BURIAL Sept 0/ 19 30

20 UNDERTAKER Sidney D. Whitehead & Sons ADDRESS 1900 Eutaw Place

Spec.—1-30—M. & T.—250 Bks

E 60509

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60509

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 347 N. Milton Ave (ST.) 6-10 (WARD)

2-FULL NAME James J. Somers

(a) RESIDENCE NO. 347 N. Milton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Annie M. Somers

6 DATE OF BIRTH (month, day, and year) Aug 3 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Water Tender 086
(b) General nature of industry, business, or establishment in which employed (or employer) Beth Steel Co
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS
10 NAME OF FATHER John D. Somers
11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)
12 MAIDEN NAME OF MOTHER Martha Rhodes
13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Annie M. Somers
(Address) 347 N. Milton Ave

15 ... 1930 G. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 1929, to Sept 11 1930,
that I last saw him alive on Sept 10 1930, at 4:45 P. m.
and that death occurred, on the date stated above, at 4:45 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of esophagus

(duration) 3 yrs. ... mos ... ds.
CONTRIBUTORY (Secondary) Pertussis
(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Ralph L Hoyt, M. D.
, 19 (Address) 262 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem
DATE OF BURIAL Sept 13/30 19
ADDRESS 2016 Orleans St

20 UNDERTAKER Philip Herwig

TION is very important. See instructions on back of Certificate.

Spec.—1-30—M. & T.—250 Bks.

240 5-33
E 60510

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60510

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST., 7-13 WARD)

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Neal

(a) RESIDENCE NO. 1006 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 23, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7 mos.	19 das.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Alphema Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va. Virginia

12 MAIDEN NAME OF MOTHER Amanda Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant JOHNS HOPKINS HOSP. Records

(Address) C. HAMPSON JONES, M. D. Asst Registrar

15 Filed SEP 13 1930 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1930, to Sept. 11, 1930, that I last saw him alive on Sept. 11, 1930, at 4:30 P.M. and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

~~Duration~~ diarrhea & enteritis

~~Antecedents~~

(duration) yrs. 1 mos da.

CONTRIBUTORY (Secondary) congenital syphilis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

9/12 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary cty DATE OF BURIAL Sept 13, 1930

20 UNDERTAKER Mrs. R. H. Elliott ADDRESS 325 Ashland Ave

E 60511 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60511

CERTIFICATE OF DEATH

170

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at Hopkins Hospital

CITY OF BALTIMORE: (NO. ..... ST., 9-18 (WARD)

2-FULL NAME Edwin Wm. Smith

(a) RESIDENCE NO 2010 Cecil Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none-retired
(b) General nature of industry, business, or establishment in which employed (or employer) Railway Clerk
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co., Md.

PARENTS

10 NAME OF FATHER Edwin Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Susannah Peters

13 BIRTHPLACE OF MOTHER (city or town) Kent Co., Md. (State or country)

14 Informant Nancy Parker

(Address) 2010 Cecil Ave

15 Filed ..... 192 ..... Registrar

SEPT 13 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 11/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot- right temple.
Suicide

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) ..... Coroner, M. D.

9/11/30 19 (Address) 606 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Sept. 13 1930

ADDRESS .....

20 UNDERTAKER Fisher & Jones died 424 N Broadway

IMPORTANT—See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 60512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 60512

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 11-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Tagmans

(a) RESIDENCE NO. Mercy Hospital ST., 1 W. Mt. Vernon Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 Hrs yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11, 1930

7 AGE	Years	Months	Days	If LESS than 1 day 17 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Tagmans

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Loretta Klug

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant (Address) Jos Tagmans 1 W Mt Vernon Place

15 Filed Sept 13 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1930, to Sept 12, 1930, that I last saw him alive on Sept 12, 1930, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Frank T. Morris, M. D.

, 19 (Address) 1129 Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Mary Florence — DATE OF BURIAL 9/13 1930

20 UNDERTAKER Chas P. Grace & Son — ADDRESS 118 W. Mt. Royal Ave

Spec.—1-30—M. & T.—250 Bks

E 60513

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

63-007 ✓

E 60513

REGISTERED NO. 13-59

1-PLACE OF DEATH Union Memorial Hospital ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Mrs Mary B. Joyner

(a) RESIDENCE NO. 2219 Linden Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State):

Length of residence in city or town where death occurred 65 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mr R. Joyner

6 DATE OF BIRTH (month, day, and year) Dec 27, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	65	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Vict or Buschmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sally Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Other

14 Informant Son, Mr. R. Norman Joyner

(Address) 2219 Linden Ave.

15 FILED SEP 13 1930 19 CLAYTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1930, to Sept 12, 1930,

that I last saw h e alive on Sept 12, 1930

and that death occurred, on the date stated above, at 9:30 Am. (Daylight Saving)

The CAUSE OF DEATH* was as follows:

Hodgkin's disease

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? 2219 Linden Ave.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Features

(Signed) Francis W Sluck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery DATE OF BURIAL Sept 15 1930

UNDERTAKER George H Smith ADDRESS 153 Hollins

Spec.—1-30—M. & T.—250 Bks

E 60514

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60514

CERTIFICATE OF DEATH.

REGISTERED NO. 155

1-PLACE OF DEATH Union Memorial Hospital 12-49

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. William Russell Hargo

(a) RESIDENCE NO. Union Memorial Hospital ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of none

6 DATE OF BIRTH (month, day, and year) March 17, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 54

(b) General nature of industry, business, or establishment in which employed (or employer) Surgical Interne

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Dr. Bunnell Hargo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Anna Kendall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Dr. Lee Fargo (bro) (Address) 36 B Walbrook Ave

Filed SEP 13 1930, 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ~~August~~ September 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 28, 1930, to September 13, 1930, that I last saw him alive on September 13, 1930, and that death occurred, on the date stated above, at 12 M. a.m. U.S.

The CAUSE OF DEATH* was as follows:

Infected Ileocolic Osteomyelitis of femur

Diabetes

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ..... Sept 4, 1930

Did an operation precede death? yes Date of Sept. 7, 1930

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Richard I Shackelford, M. D.

9/13/1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 15, 1930

20 UNDERTAKER Stewart Memorial Co

ADDRESS Balto.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60515 E 60515

CERTIFICATE OF DEATH.

90

REGISTERED NO. 28-63

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara A. Byrne

(a) RESIDENCE NO. Lancaster. Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David R. Byrne

6 DATE OF BIRTH (month, day, and year) Aug 21 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Altemont Pa.

PARENTS

10 NAME OF FATHER Patrick Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Tully

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York New York

14 Informant Mt Hope Retreat (Address) Mt Hope Retreat.

15 SEP 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11. 1930

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to Sept 11, 1930,

that I last saw h[illegible] alive on Sept 10, 1930,

and that death occurred, on the date stated above, at 8.45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic - Myocarditis

(Cardiac Failure)

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Depression Psychosis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) Julian P. Hall, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peter's Cemetary, Columbia. Pa. DATE OF BURIAL Sept/15/30

20 UNDERTAKER Stewart & Mowen Company - 108 W. North Avenue. ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 60516 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60516

CERTIFICATE OF DEATH.

90

REGISTERED NO. 1359

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apts. ST. 5 A. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Block

(a) RESIDENCE NO. Esplanade Apts. 5 A. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon S Block

6 DATE OF BIRTH (month, day, and year) Dec 3, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Moritz Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Cecilie Richman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. S Block. (Address) 2412 Brookfield Ave

15 Filed ..... 19..... C. HARRISON JONES, M. D. Registrar

1 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Sept 12, 1930, that I last saw h[er] alive on Sept 12, 1930, and that death occurred, on the date stated above, at 2 15 P.M.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Luft, M. D.

9/12, 1930 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 9/14/1930

20 UNDERTAKER Baird Loudenslager & Son

ADDRESS 1912 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Bks.

E 60517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-09 E 60517

12-30

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Hopkins Hosp. ST. WARD)

2—FULL NAME Daniel C. Coblens

(a) RESIDENCE NO. Hopkins Hosp. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Tolson Coblens

6 DATE OF BIRTH (month, day, and year): May 12, 1852

7 AGE: Years 78 Months 3 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Clerk-Tax Dept. Balto.

9 BIRTHPLACE (city or town) (State or country): Ind.

PARENTS

10 NAME OF FATHER: Charles Coblens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Leon Coblens

(Address) Emerson Apts.

15 Filed: 1 3 1930 19 By: C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 14, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1930, to Sept 11 1930.

that I last saw h— alive on Sept 11 1930

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

CONTRIBUTORY (Secondary) uremia (duration) 5 yrs. mos. ds.

Broncho-pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Leitz, M. D.

Sept 12. 1930 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem.

DATE OF BURIAL: 9/15/1930

20 UNDERTAKER: David Sondheim & Son

ADDRESS: 1902 Eutaw Place

Spec.—1-30—M. & T.—250 Bks.

E 60518 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60518

CERTIFICATE OF DEATH.

REGISTERED NO. 33

1-PLACE OF DEATH Baltimore City Hospital. ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Charlie Folson

(a) RESIDENCE NO. 1704 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col.	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1715

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Folson ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Beulah Cotton ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Friends Baltimore City Hosp.

(Address)

15 Filed 1-3 1930 19 C. HAMPSON JONES, Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10-30

17 I HEREBY CERTIFY, That I attended deceased from 7-23-, 1930, to 9-10-, 1930, that I last saw h— alive on 9-10-, 1930, and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis (Appx)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 7-23-30

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy

(Signed) Fred M. Duckenwald, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Sept 13, 1930

20 UNDERTAKER Chas. Tilp R. Williams

ADDRESS 3221 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

042391 E 60519

HEALTH DEPARTMENT—CITY OF BALTIMORE E 60519

CERTIFICATE OF DEATH. X 38

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Alice Waters

(a) RESIDENCE NO. Worton - Md ST., WARD
(Usual place of abode) Colemans Corner, Kent Co. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER ~~Edward~~ Waters

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ardelia Wright

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 13 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 9/30

17 I HEREBY CERTIFY, That I attended deceased from September 4, 1930 to September 9, 1930, that I last saw her alive on September 9, 1930, and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:

Dysentery, Ac bacillary

(duration) 3 weeks yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis, Congenital

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Exam of stools Wasserman reaction

(Signed) Mary Adams, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: SEP 11 1930

UNDERTAKER — ADDRESS

Commissioner of Health

Spec.—1-30—M. & T.—250 Bks

E 60520

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60520

CERTIFICATE OF DEATH.

REGISTERED NO. 162

1-PLACE OF DEATH Maryland University Hospital

CITY OF BALTIMORE: (NO. 14-16 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Edward Simmons

(a) RESIDENCE NO. 337 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Father
(Address)

15 Filed 13 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Sept 7, 1930, that I last saw him alive on Sept 7, 1930, and that death occurred, on the date stated above, at 1:40 P.m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia, right (contributory)

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. C. Hudson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL SEP 13 1930, 19

ADDRESS

20 UNDERTAKER Commissioner Health.

Spec.—1-30—M. & T.—250 Bks

E 60521

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60521

CERTIFICATE OF DEATH.

167-081

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 W. Mulberry ST., 4-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Howard

(a) RESIDENCE NO. 607 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Oliver Quigzino

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Christine Howard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant
(Address)

Filed SEP 13 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1930, to Sept 10, 1930,

that I last saw her alive on Sept 9, 1930,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

26 wks.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? History & Exam.

(Signed) [illegible] M. D.

Sept 13 1930 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: SEP 13 1930

20 UNDERTAKER: Commissioner Health

ADDRESS

C. HAMPSON JONES, M. D.
Registrar

BY AM E WOODAL

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60522

161-001 ✓ E 60522

REGISTERED NO. 26-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 S. Fagley ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Lanit

(a) RESIDENCE NO. 900 S Fagley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10-1930

7 AGE	Years	Months	Days	If LESS than 1 day ~~22~~ hrs. or ~~min.~~
			X 22 hrs	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Lanit

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Theresa Fackley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant

(Address)

15 Filed 3-1930, 19 HARRISON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11-30

17 I HEREBY CERTIFY, That I attended deceased from 9. 10., 1930, to 9. 11, 1930,

that I last saw h er alive on 9-11, 1930

and that death occurred, on the date stated above, at 8 30 PM m.

The CAUSE OF DEATH* was as follows:

Prematurity

(5 mos. fetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dudley P Bowe, M. D.

9. .1930 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

In Potters Field

ADDRESS

20 UNDERTAKER

SEP 13 1930

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60523 E 60523

CERTIFICATE OF DEATH.

13-59 29

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3102 Auchentoroly Terrace WARD)

2-FULL NAME Florence Mansfield

(a) RESIDENCE No. 3102 Auchentoroly Terrace WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo F Mansfield

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER George S. Morris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eamar Prentiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant George F. Mansfield
(Address) 3102 Auchentoroly Terrace

15 1 3 1930 C. HARPSON JONES, Jr., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. , 1928 , to Sept 13 , 1930 , that I last saw h alive on Sept 12 , 1930 , and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Moses, M. D.

Sept 13 1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 9/15 1930

20 UNDERTAKER Henry W. Mearskon

ADDRESS 2654 Calvert St.

TION is very important. See instructions on back of Certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60524 E 60524

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hanover & Sept 1930 (ST.) (WARD)

2-FULL NAME Henry H. Rollins

(a) RESIDENCE NO. Odenton Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day and year) Unknown 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Lee Rollins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Hadley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant James H. Botts (Address) Odenton Md.

15 Filed SEP 17 1930 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 19 30, to Sept 13, 19 30

that I last saw h[illegible] alive on Sept 13, 19 30

and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) ..... yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary) Congestive Cardiac Failure (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 11 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & symptoms

(Signed) Henry [illegible] M. D.

, 19 (Address) Hanover Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dameseville Va.

DATE OF BURIAL 9/16 1930

20 UNDERTAKER J Loyd Kaiser

ADDRESS Laurel Md

1-30—M. & T.—100 B—50L

E 60525

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60525

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) N B G Hospital ST., 16-68 WARD

2-FULL NAME Helen L Lacey

(a) RESIDENCE No. 124 Smithmont Ave ST., Catonsville Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8, 1928

7 AGE: Years 2 | Months 8 | Days 5 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS
10 NAME OF FATHER Harold F. Lacey
11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois
12 MAIDEN NAME OF MOTHER Helen M. Bloom
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harold F. Lacey
(Address) 124 Smithmont Ave.

15 Filed ... 1930 ... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:
Acc Burns
Staying with patient

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)* Shock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Catonsville

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) G E Slades, M. D.
Coroner

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem
DATE OF BURIAL: 9/16 19 30.

20 UNDERTAKER: Easton Sons
ADDRESS: Ellicott City

HAMPTON JONES, M. D.

1-30—M. & T.—100 B—50L

E 60526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002

E 60526

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 28 Lloyd ST. 3-5 WARD)

2-FULL NAME Moses Dubow

(a) RESIDENCE NO 28 Lloyd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Oscar Dubow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Raymond Dubow

(Address) 1011 E Lombard St

15 Filed SEP 14 1930 192 HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Arterio Sclerosis

(duration) yrs. mos — ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) C. G. Grades, M. D. Coroner

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern cem

DATE OF BURIAL Sept 14 1930

ADDRESS 1117 E Balto St

20 UNDERTAKER S Lemson Bro

Spec.—2-29-28—L. F. S.—500 Bks.

Sparrow

161-001 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60527

REGISTERED NO. E 60527

1—PLACE OF DEATH

(CITY OF BALTIMORE: (No.) 2822 Hunting ST. (WARD) 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Sparrow

(a) RESIDENCE NO. 2822 Huntingdon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

7 DATE OF BIRTH (month, day, and year) Sept 10, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Frank A Sparrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lydia F Masimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frank A. Sparrow

(Address) 2822 Huntingdon Ave

15 Filed SEP 14 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 11 1930 to Sept 13 1930

that I last saw h. alive on Sept 12 1930

and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition Immaturity

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Fatal

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W Brady M. D.

19 (Address) Medical Dr Telly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL Sept 15 19 30

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Bks

E 60528

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60528

CERTIFICATE OF DEATH.

REGISTERED NO. 27-43 88

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 5909 Arabia Ave ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Winfield Cousins

(a) RESIDENCE NO. 5909 Arabia ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND) of or) WIFE of Chrisarfe E.

6 DATE OF BIRTH (month, day, and year) Jan. 4 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Harp Co.

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Louis H. Cousins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Rees

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Chrisarfe E Cousins

(Address) 5909 Arabia Ave

15 FILED 1-4 1930 19 E. J. JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12/30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Sept 12, 1930, that I last saw h/ alive on Sept 12, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(duration) 6 yrs. mos da.

CONTRIBUTORY (Secondary) Cerebral Embolus (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jamison G Voss M. D.

, 19 (Address) 5106 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Sept 15 1930

DATE OF BURIAL

20 UNDERTAKER H. Cook 1247

ADDRESS 50 Park

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60529 | 129 E 60529

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2918 Westwood Ave ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emelie Schmidt

(a) RESIDENCE NO. 2918 Westwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Gustav H Schmidt

6 DATE OF BIRTH (month, day, and year) Jan 6 th 1846

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	8	6	

8 OCCUPATION OF DECEASED at home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Zehner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Marie Schilling

(Address) 2918 Westwood Ave

Filed P 1-4 1930 C. Hamilton JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1930

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to Sept 12, 1930,

that I last saw h[illegible] alive on Sept 12, 1930

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs, Uremia

Chronic Interstitial Nephritis

Arteriosclerosis (duration) Myocardial Heart

CONTRIBUTORY (Secondary) insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G Webster M. D.

Sept 13, 1930 (Address) 6409 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 1930 Sept 15 ~~1930~~

ADDRESS [illegible] Orleans

UNDERTAKER John Ullrich

Spec.—1-30—M. & T.—250 Bks.

60530

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159,001
B 60530

REGISTERED NO.

1-PLACE OF DEATH Woman's Hospital 28-644 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) T. M.

2-FULL NAME Baby Jutta Duehrssen

(a) RESIDENCE NO. 3612 Eldorado Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 4, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Kurt F. Duehrssen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Weimar, Germany

12 MAIDEN NAME OF MOTHER Ilse Montua

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Falkstaedt, Poland

14 Informant Kurt F. Duehrssen

(Address)

15 FILED 1-4 1930 19 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Sept 7, 1930, that I last saw her alive on Sept 7, 1930, and that death occurred, on the date stated above, at 7:30 P m. EST

The CAUSE OF DEATH* was as follows:

Internal Hydrocephalus (Congenital)

(duration) 0 yrs. 2 mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes (of head only)

What test confirmed diagnosis? Clinical

(Signed) Earle P. Clemson, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carnegie Lab.

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

Spec.—1-30—M. & T.—250 Bks

E 60531

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60531

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2017 E Monument ST., 7-9 WARD)

2-FULL NAME Josephine Kaiser

(a) RESIDENCE NO. 2017 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Joseph Kaiser

6 DATE OF BIRTH (month, day and year) Feb 14 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Waldhauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Flos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabeth Dietz

(Address) 2017 E. Monument St.

Filed Sept 16 1930, 19 [illegible] JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12/30

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19 30, to Sept 12, 19 30, that I last saw h Ex alive on Sept 11, 19 30, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerosis

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Ward M. D.

9/14/30 (Address) 416 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Sept 16 19 30

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St.

Spec.—1-30—M. & T.—250 Bks.

E 60532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

102 E 60532

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp ST. 1-3 WARD)

2-FULL NAME Carney Ridgell

(a) RESIDENCE NO. 2125 Eastmdg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 3-4-0

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country) St Marys Co. Md

PARENTS

10 NAME OF FATHER Robert Ridgell

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Lula Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co

14 Informant Robert Ridgell (Address) Scotland St Marys Co. Md

15 Filed 1-4 1930 C. HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 14, 1930, that I last saw him alive on 1.15 am D.S.T., 1930, and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows:

Multiple Lung abscesses

Non Traumatic

Non Tuberculous.

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary) Bilateral Empyema

(duration) yrs. mos 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post Mortem Exam.

(Signed) Saul Weisman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Michaels Cemetery St Marys Co Md

DATE OF BURIAL 9/14/30.

UNDERTAKER E. L. Robinson

ADDRESS Dinerons, St Marys Co

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 60533

E 60533

CERTIFICATE OF DEATH.

X 45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Union Memorial Hosp't 2-46 WARD)

2-FULL NAME Mrs. Wm. Kelly.

(a) RESIDENCE NO. Reedsville, Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Mrs. Wm. Kelly (Helen)

6 DATE OF BIRTH (month, day, and year) Nov. 12, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Saw Mill~~ Opr.

(b) General nature of industry, business, or establishment in ~~which employed (or~~ employer) Saw Mills 046

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Reedsville Penna.

PARENTS

10 NAME OF FATHER Joseph V. Kelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Barbara Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Joseph Kelly (Address) Reedsville Pa

15 Filed 4-1930, 19 HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 13, 1930.

that I last saw him alive on Sept 13, 1930;

and that death occurred, on the date stated above, at 9 P m. D.S.T.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Carcinoma of Sigmoid

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 9-8-30

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Michael J. Crawford, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reedsville Pa

DATE OF BURIAL 9/14/30

20 UNDERTAKER Chas J. Grace & Son

ADDRESS 1811 Druid Park Ave

Cor.—12-9-15—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60534

E 60534

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hosp. St. 2-4 Ward)

2-FULL NAME Paul Victor Ziranski

(a) RESIDENCE NO. 817 S. Ann St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1922

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	8	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Vinceslaus Ziranski

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Poland

12 MAIDEN NAME OF MOTHER Genevinie Myslinski

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Mt. Carmel Pa.

14 Informant Vinceslaus Ziranski

(Address) 817 S. Ann St.

15 Filed _____ 19 _____ _____ Registrar

1 4 1930

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Its death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Glazing) A G Drowning

(duration) _____ yrs. _____ mos. — ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) _____ yrs. _____ mos. — ds.

16/50 (Signed) J C Slade M. D.

(Coroner)

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Front of Ann St.

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Brooklyn Date of Burial Sept 15 1930

20 UNDERTAKER John M Weber ADDRESS 4114 Chester Ave

HAMPSON JONES

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 60535

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 N Carlton St. 18-N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sophia Gough

(a) RESIDENCE NO. 226 Carlton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Gough Deceased

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 56; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): H Mays Co.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Dorothy Mack

(Address) 226 Carlton Ave

15 Filed SEP 14 1930, 19 C. P. JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-12 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-6-, 1930, to 9-12-, 1930, that I last saw her alive on 9-9-, 1930 and that death occurred, on the date stated above, at 3.15 p. m.

The CAUSE OF DEATH* was as follows:

Cardio vascular renal disease Hypertension.

Terminal Broncho-pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardio vascular renal disease (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. L. Jackson, M. D.

9/13/1930 (Address) 600 Marlyn Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery

DATE OF BURIAL: Sept 15 1930

20 UNDERTAKER: Mrs. Kate R Williams

ADDRESS 322 N Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 60536

E 60536

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 Chelsea Terrace ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Thea Watson

(a) RESIDENCE NO. 2109 Chelsea Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 7 mos. 16 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced, (or) WIFE of William H Watson Jr

3 DATE OF BIRTH (month, day, and year) January 28th 1887

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	7	16	

OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER William Pfefferman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louise C Watson

(Address) 2109 Chelsea Terrace

15 Filed 1930 19 MARION JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13-1930

17 I HEREBY CERTIFY, That I attended deceased from January 1 19 27 to September 13 19 30.

that I last saw her alive on September 11 19 30

and that death occurred, nn the date stated above, at 1:45 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) none (duratinn) yrs. mos. ds.

18 Where was disease cnntracted if not at place of death?

Did an operation preccde death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms.

(Signed) Chester Riland, M. D.

9-13 19 30 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Sept 15th 1930

20 UNDERTAKER George Schulling & Sons

ADDRESS 1126 E Monument

Spec.-7-17-26—A Co.—200 Bks.

E. 60537

HEALTH DEPARTMENT—CITY OF BALTIMORE 60537

CERTIFICATE OF DEATH

74-001

REGISTERED NO. 2697

1-PLACE OF DEATH

City of BALTIMORE: (No. 1557 Argyle Ave. St. 4-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Bond

(a) RESIDENCE NO. 1557 Argyle Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE: Years 68 Months — Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coachman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): St Mary Co. Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) (State or country):

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Mrs Nellie Lawrence 1557 Argyle Ave

15 Filed 1-5 1930

16 Registrar: C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-12 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-30, 1930 to 9-12, 1930 that I last saw him alive on 9-12, 1930 and that death occurred, on the date stated above, at 11.40 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Chronic Arthritis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Medical tests

(Signed) W. Estell Jones M. D.

19 (Address) 1123 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

20 UNDERTAKER: Daniel Carter

Date of Burial: 9-15 1930

ADDRESS 916 Cathedral

very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60538 — E 60538 REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 619 Dolphin St., 17-24 (Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kenner
(a) RESIDENCE No. 619 Dolphin St., Ward
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Cuthbert
(Address) 619 Dolphin St

15 Filed SEP 15 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12-1930

17 I HEREBY CERTIFY, That I attended deceased from June 1930, to Sept 12, 1930, that I last saw her alive on Sept 11, 1930, and that death occurred, on the date stated above, at 5 A 20 m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular disease
Do not Know
(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Rheumatism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H K Conner, M. D.
9-13, 1930 (Address) 417 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park
DATE OF BURIAL 9-15-1930
20 UNDERTAKER Daniel Carter
ADDRESS 916 Pa Ave

Registrar

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60539 — REGISTERED NO. 84 E 60539

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 60539

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1018 Russell ST. 21-24 WARD)

2-FULL NAME Margaret Nuffer

(a) RESIDENCE NO. 1018 Russell ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Nuffer

6 DATE OF BIRTH (month, day, and year) Dec. 5. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jonathon Kilgus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Schuld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Nuffer (Address) 1018 Russell St

15 Filed SEP 15 1930 C. BANKS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept. 13, 1930, that I last saw her alive on Sept. 13, 1930, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

General Asteriosclerosis
Sclerosis of Coronary arteries
(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) angina pectoris (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. F. Marx M. D.

(Address) 576 Cathedral St

9-17 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Sept 16 1930.

20 UNDERTAKER Fun. Dir. John H. Tempel & Son — ADDRESS 801 W. Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60540 | 129 | E 60540

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE—No. 417 Rock Glen Road (If not in hospital) WARD 21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Hannemann

(a) RESIDENCE NO. 417 Rock Glen Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed or divorced, HUSBAND of (or) WIFE of Christian Hannemann

6 DATE OF BIRTH (month, day and year) Aug. 31, 1842

7 AGE Years 88 Months # Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Seitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Resch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary C. Beck (Address) 417 Rock Glen Road

15 Filed 10 15 1930 (19) HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1925 to Sept. 13 1930.

that I last saw h alive on Sept. 13 1930.

and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Chronic Myocarditis

Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Jones M. D.

9-13, 1930 (Address) 516 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Sept 15 1930

20 UNDERTAKER Eastern Sem. ADDRESS Edmondson

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60541

E 60541

CERTIFICATE OF DEATH.

† 37-00 60541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves ST. 26-12 (WARD)

2-FULL NAME Howard Grimes

(a) RESIDENCE NO. Elkridge, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: May Fet. 18, 1905

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 25 Months 9 Days 14.

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer): Farm

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: William Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ellen Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant (Address): May Grimes Elkridge Md

15 Filed SEP 15 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 — 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-10 —, 1930, to 9-14, 1930, that I last saw him alive on 9-14 — 1930, and that death occurred, on the date stated above, at 5 45 a.m. Standard

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign.

(Signed) Hjalmar S Anderson M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lutheran Cakel

DATE OF BURIAL: Sept. 16 1930

20 UNDERTAKER: Morgan & Flynn

ADDRESS: [illegible]

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60542

E 60542

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hosp. ST. 16-67 WARD)

2-FULL NAME Christopher Robert Warnken

(a) RESIDENCE NO. 743 Linnard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Gertrude Morpeth Warnken

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing Supply Co.

(c) Name of employer James Robertson Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Jerdine Warnken

11 BIRTHPLACE OF FATHER (city or town) Bremen (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Berlinecke

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)

14 Informant Mrs. Christopher Warnken, Wife

(Address) 743 Linnard St.

15 FILED SEP 15 1930 HARRY JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930, to Sept. 14, 1930, that I last saw him alive on Sept 14, 1930, and that death occurred, on the date stated above, at 5-20 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency, acute; Dilatation of heart, acute, sudden,

(duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Asthma (cause unknown)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diag. & History

(Signed) R. E. Ludeke, M. D.

, 19 (Address) University of Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 9/17/30

ADDRESS

20 UNDERTAKER Geo. Weber & Son 2503 Edmondson Ave

Spec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60543

CERTIFICATE OF DEATH

44

REGISTERED NO. E 60543

1—PLACE OF DEATH 3800 Third st. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Brooklyn, Md ST. 25-75 WARD)

2—FULL NAME Charles Philip Myers Sr.

(a) RESIDENCE NO. 3800 Third St, Brooklyn, Md WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 1 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

6 If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Louisa J. Eckhardt Myers

7 DATE OF BIRTH (month, day, and year) July 20th 1867

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer) meter dept.

(c) Name of employer Balto. City

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Philip Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Kate Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa J. Myers

(Address) 3800 Third St

15 FILED SEP 15 1930 Registrar

P 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to Sept 12, 1930, that I last saw h— alive on Sept. 11, 1930; and that death occurred, on the date stated above, at 2.30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. mos. ds.

CONTRIBUTORY, (Secondary) Senility Hypertrophy of Prostate

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of July 29

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Abram, M. D.

, 19 (Address) 126 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 9/15/1930

ADDRESS

20 UNDERTAKER Geo. Weber & Son - 2563 Edmondson Ave

Spec.—1-12-23—M&T—100 Bks.

E 60544 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60544

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH West Balt. Gen. Hospital 15-68

CITY OF BALTIMORE: (NO. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Louis Kammetsky

(a) RESIDENCE NO. 1800 N. Pulaski St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Kammetzky

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 53 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mendel Kammetzky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1439 E. Balto St.

15 Filed 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14/30 19

17 I HEREBY CERTIFY, That I attended deceased from 9/6/30, 19, to 9/14/30, 19, that I last saw h[illegible] alive on 9/14/30, 19, and that death occurred, on the date stated above, at 12:20 Pm.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) myocardial Failure

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of No

Was there an autopsy? No

What test confirmed diagnosis? Urine + Blood Exam.

(Signed) H Cashman, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel

DATE OF BURIAL - 1 - 1930

20 UNDERTAKER Jacob Lewis, 1439 E Balto St

ADDRESS

Spec.—1-30—M. & T.—250 Bks

60545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60545 E

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) University Hospital (Ward) 4-30

2-FULL NAME Mr. Rupert Hesser (Over Turning Co.)

(a) RESIDENCE NO. Old Frederick Road WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud Corkran Hesser

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	10	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Asst. Master Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) R.R.
(c) Name of employer B. & O. R. R. Grafton

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Andrew J. Hesser

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Coldericker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Mrs. Maud C. Hesser
(Address) Old Frederick Rd.

15 Filed 1 5 1930 19 H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1930, to Sept 12, 1930, that I last saw h[illegible] alive on Sept 12, 1930, and that death occurred, on the date stated above, at 12¹⁰ A m.

The CAUSE OF DEATH* was as follows:
Ulcer duodenal, perforated.
Peritonitis, generalized.
(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Pulmonary embolism.
(duration) yrs. mos. 10 min

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 31, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George N Yeager, M. D.
9/12, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk. DATE OF BURIAL 9/15 1930

20 UNDERTAKER Harry A. Lutz Co. ADDRESS 4101 E. Monument Ave.

-30—M. & T.—100 B—50L

60546

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 ✓

E 60546

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3412 Ravenswood Ave ST., 8-40 WARD)

2-FULL NAME Joseph A. Geis

(a) RESIDENCE NO 3412 Ravenswood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Geis

6 DATE OF BIRTH (month, day, and year) Apr 16/1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	4	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Straw Hat Blocker
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer Brigham & Hopkins

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Leonard Geis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Md.

12 MAIDEN NAME OF MOTHER Frances Sweiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Leona Bright (daughter)
(Address) 3412 Ravenswood Ave.

15 Filed SEP 15 1930, 192 — Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 14/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure- Alcoholism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Geis, M. D.
Coroner

19 (Address) 3088 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer Cemetery

DATE OF BURIAL Sept 17 1930

20 UNDERTAKER Sargent Pasch

ADDRESS 2406 Ashland ave

G. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60547 — REGISTERED NO. E 60547

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 Druid Hill Ave.) (WARD) 6-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Atwell Lewis Plair

(a) RESIDENCE NO. 1130 Druid Hill Ave. ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year): 1886

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

BIRTHPLACE (city or town) (State or country): N. C.

10 NAME OF FATHER: William Plair

11 BIRTHPLACE OF FATHER (city or town) (State or country): N-C.

12 MAIDEN NAME OF MOTHER: Mary Gilmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Lillie Plair

(Address) 1130 Druid Hill Ave

15 Filed ..., 19... — [illegible] JONES M. Registrar

5-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/12/30

17 I HEREBY CERTIFY, That I attended deceased from 9/9/30, to 9/12/30, that I last saw him alive on 9/12/30, and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Howard M. D.

(Address) 912 Eutaw St

9/12/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Sept 15 1930

20 UNDERTAKER: John N Jenkins

ADDRESS 1027 Hanover

Rev. 2-29-28—L. F. S.—500 Blks.

E 60548

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60548

CERTIFICATE OF DEATH

REGISTERED NO. 9-46

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2752 Alameda Blvd ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret C. Ohlgart

(a) RESIDENCE NO. 2752 Alameda Blvd ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 7 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced (or) WIFE of Louis Ohlgart

DATE OF BIRTH (month, day, and year) Jan 29 1870

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	7	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Valentine Kohlhepp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Fraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Ohlgart

(Address) 2752 Alameda Boulevard

Filed 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13-30

17 I HEREBY CERTIFY, That I attended deceased from 9-2-, 1930 to 9-13-, 1930; that I last saw her alive on 9-13-, 1930 and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 mos. 11 ds.

CONTRIBUTORY (Secondary) Ac. Cardiac Dilatation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Dyhert, M. D.

19 (Address) 280 x Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 16 1930

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument

Spec.—1-30—M 45—250 Bks.

E 60549

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (NO. Caroline & Aliceanna ST. 23-33 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Charles E Palmer

(a) RESIDENCE NO. 1339 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Hanna B. Palmer 186

6b DATE OF BIRTH (month, day, and year) March 8, 1866

7 AGE: Years 67 | Months 6 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S.

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Hanna B. Palmer

(Address) 1339 S. Charles St

15 Filed SEP 13 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5 th, 19 30, to Sept 12 th 19 30, that I last saw h[illegible] alive on Sept 12 th, 19 30, and that death occurred, on the date stated above, at 1 20 p. m.

The CAUSE OF DEATH* was as follows:

chronic myocardial degeneration with decompensation

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Sept 13 1930

UNDERTAKER C. Howard Evans ADDRESS 3 E. Fort Ave

Cor.—1-12-28—M&T—100 Bks.

E 60550

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60550

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2509 Guilford Av. St., 12 WARD

2-FULL NAME Iowa Rebecca Abbott

(a) RESIDENCE NO. 2509 Guilford Av ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 68 yrs. 4 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph A. Abbott

6 DATE OF BIRTH (month, day, and year): April-22-1862

7 AGE — Years: 68 | Months: 4 | Days: 21 | If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Maryland.

PARENTS

10 NAME OF FATHER: David K. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown U. S. A.

12 MAIDEN NAME OF MOTHER: Christine Stephan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Germany

14 Informant (Address): Clement V. Abbott - (Son) 2932 Clifton Ave.

15 Filed: SEP 13 1930

H. MASON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Tabular Disease Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Edentious) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

(Address) 2632 Reisterstown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death? — — — — — —

Former or usual residence — — — — — — — —

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Sept 15 1930.

UNDERTAKER: Stewart & Monroe Company — ADDRESS: Balto.

1-30—M. & T.—100 B—50L

E 6055I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 6055I

REGISTERED NO. ____

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) 1613 Druid Hill Ave. (Ward) 11-20

2-FULL NAME Truman Autrum

(a) RESIDENCE NO. 1613 Druid Hill Ave. ST., ____ WARD ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C	A.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ____

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ____

14 Informant Thomas Chase

(Address) 1402 Mosher

15 Filed ____ 1930 Registrar

16 Map ____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide
Jumped from 3rd Story Window
Multiple Fractures

(Duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Shock (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) C. E. Gladden Coroner, M. D.

9-13 1930 (Address) 1430 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Lubarn

DATE OF BURIAL Sept 15 1930

ADDRESS ____

UNDERTAKER Thos. H. Chase Sons 1402 Mosher

SEP 15 1930

MARION JONES, M. Registrar

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60552

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 60552

1-PLACE OF DEATH

City of Baltimore: (No. 801 Garrison Blvd near Garrison Blvd) (St.) (Ward) 24-50

2-FULL NAME Herbert J Horn

(a) RESIDENCE NO. 4506 E 22nd St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 10 mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto Business
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1 yr.
(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Geo. M. Horn

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Kelly

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Mrs Mary Alice Horn
(Address) 4506 E 22nd St

FILED SEP 15 1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Gas Poisoning Auto Gase

(Duration) ..... yr. ..... mos. — ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted? —
If not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? History

(Signed) G C Gladis, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept. 15 1930
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Sons	M & Sa Ave.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60553 44 E 60553

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5316 Surrym Oak Ave St. 28-64 WARD)

2-FULL NAME David Hare

(a) RESIDENCE NO. 5316 Surrym Oak Ave St. WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Clara P. Hare

7 DATE OF BIRTH (month, day, and year) Dec. 4, 1859

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	8	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter Builder

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self Balto Co.

10 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER David Hare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Clara P. Hare

(Address) 5316 Surrym Oak Ave.

15 Filed 1930 19 Harry Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 30, to Sept 12, 1930

that I last saw him alive on Sept 12, 1930

and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Richardson M. D.

Sept 15, 1930 (Address) 112 W. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dater's Cem. Balto Co. Md

DATE OF BURIAL Sept 15, 1930

20 UNDERTAKER Wm J. Heckner & Sons

ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 V

REGISTERED NO. E 60554

E 60554

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2695 WILKENS AVENUE ST. 20-72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME EMELIA MILLER

(a) RESIDENCE NO. 2695 WILKENS AVENUE ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of JOHN MILLER

7 DATE OF BIRTH (month, day, and year) December 27" 1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
75		8	13 16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Mr Steffeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John G. Miller

(Address) 2695 Wilkens Avenue

15 Filed 9 15 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13" 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept-13, 1930.

that I last saw h alive on Sept-12, 1930

and that death occurred, on the date stated above, at 3.35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas and Metastasis

(duration) yrs. 7 mos. 12 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) James D. Lansburgh M. D.

9/14 1930 Address 2729 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Sept. 16" 30

20 UNDERTAKER Joseph H Cook

ADDRESS 1002 N Gay St

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60555

CERTIFICATE OF DEATH

90 E 60555

REGISTERED NO. 16-69

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2730 Edmondson Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte E Hahn

(a) RESIDENCE NO. 2730 Edmondson Ave ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced: (or) WIFE of Wm C Hahn

DATE OF BIRTH (month, day, and year): June 28, 1860

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Charles Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Lenkuhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: MB Gordon Matthews

(Address) 2730 Edmondson Ave

Filed SEP 15 1930 HARRY M. JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): September 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 18 1930 to Sept 12 1930

that I last saw her alive on Sept 12 1930

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chron. Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) P Gus Cox Dill M. D.

9 12 1930 (Address) 1433 N Lombard Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Sept 15 1930

ADDRESS: 1003 N Calvert St

UNDERTAKER: Poe & Cook

pec.—1-30—M. & T.—250 Blks.

60556

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph Hospital REGISTERED NO. 1428

CITY OF BALTIMORE: (No.) 6 Kirkwood St., (Ward) 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Bell

(a) RESIDENCE NO. 1826 Dover St., (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Married

7 DATE OF BIRTH (month, day, and year) Feb. 1885

8 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	7	—	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

10 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Conrad Bolte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward H. Bell

(Address) 614 Monroe St

15 1-5 1930 16 Filed 19 Registrar

17 JASON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-12-30

17 I HEREBY CERTIFY, That I attended deceased from 8-23-30, 19..., to 9-12-30, 19...

that I last saw h alive on 9-12-30, h...

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus,

Complications,

Myocarditis

(duration) 4 yrs mos ds

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 9/12/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operation

(Signed) A B Kinder, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampstead Md

DATE OF BURIAL Sept 12 19 30

20 UNDERTAKER A. Jones

ADDRESS 1111 Gilmor

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

60557 E 60557

CERTIFICATE OF DEATH.

60557

REGISTERED NO. 31

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3703 Yosemite ave ST. 5-62 (WARD)

2-FULL NAME Jeanette Rice

(a) RESIDENCE NO. 3703 Yosemite ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of Oden Rice

7 DATE OF BIRTH (month, day, and year) June 7, 1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	68	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annundel Co Md

PARENTS

10 NAME OF FATHER John Hoye

11 BIRTHPLACE OF FATHER (city or town) Annundel Co Md (State or country)

12 MAIDEN NAME OF MOTHER Jeanette Laramore

13 BIRTHPLACE OF MOTHER (city or town) Annundel Co Md (State or country)

14 Informant Mrs. Ada Hoye

(Address) 3703 Yosemite ave

15 Filed SEP 15 1930, 19 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Sept 14, 1930, that I last saw h[illegible] alive on Sept 1 - 1930, and that death occurred, on the date stated above, at 1 pm.

The CAUSE OF DEATH* was as follows:

Cer. T.B.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy. Ex

(Signed) Geo. Elmer Brady, M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Millersville Annundel Co DATE OF BURIAL Sept 16, 1930

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Balto St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60558

CERTIFICATE OF DEATH

1883 103

E 60558 REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. St. Balto Gen Hosp St., 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys M. Jones

(a) RESIDENCE NO. 904 Arlington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas Jones

6 DATE OF BIRTH (month, day, and year) May -, 1910

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	20			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Myers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Alice Dorsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant James Jones
(Address) 631 Westwood ave

15 Filed 19 Regis.

1 5 1930 HAMPSON JONES

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
While riding in a Motorcycle it collided with an unknown automobile throwing individual to roadside (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract. R. Leg
Gas Bacillus Infection (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Annapolis Rd (City)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Hamm, M. D.

9 15 1930 (Address) 1931 Mt Ephraim Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — DATE OF BURIAL Sept 19 1930

20 UNDERTAKER Thomas E Kelson — ADDRESS 1303 Pennsylvania

Spec.—8-16-29—L. F. S.—100 Bks.

E 60559

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60559

129

CERTIFICATE OF DEATH

REGISTERED NO. 16-67

1—PLACE OF DEATH 2920

CITY OF BALTIMORE: (No. Prestman st. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph H. Bennanzar

(a) RESIDENCE NO. 2920 Prestman St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Julian A. Ritter

7 DATE OF BIRTH (month, day, and year) May 10, 1836

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	94	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER John T. Bennanzar

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Elizabeth Hemlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Charles R. Sharretts

(Address) 15 Seminole Ave.

15 Filed 1930 C. Elmer Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23 1930, to Sept. 12 1930, that I last saw h. liv alive on Sept. 12 ck 1930 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Arteres-Sclerosis, Chronic Myo-carditis and Chronic Interstitial Nephritis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Isaac L. Dickson, M. D.

Sept. 13 1930 (Address) 3055 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Sept. 15, 30

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Plac

Mitchell Mitchell

Asa H Yale

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

122-001

E 60560

E 60560

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 14-47 ST., (WARD)

2—FULL NAME Harry Yates

(a) RESIDENCE NO. Bard Hills, Md ST. Washington

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Della

DATE OF BIRTH (month, day, and year) Nov. 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	10		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Mathew Yates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Alonzo Yates

(Address) Harpers Ferry, Va.

Filed 9-15-1930 H. [illegible] JONES M. D. Registrar

151330

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13-30

17 I HEREBY CERTIFY, That I attended deceased from 8-23, 1930, to 9-13, 1930.

that I last saw h. alive on 9-13, 1930

and that death occurred, on the date stated above, at 3:50 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver, with ascites

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical laboratory

(Signed) W. Peddicord, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. James Cemetery Reptn

DATE OF BURIAL 9/15/1930

UNDERTAKER Wm. Geo. H. Holland

ADDRESS 1631 Druid Hill

Spec.—1-30—M. & T.—250 Blks

E 60561

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

CERTIFICATE OF DEATH.

REGISTERED NO. E 60561

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (No.) 13-59 ST., (WARD)

2-FULL NAME: Clarence William

(a) RESIDENCE NO. 2570 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Divorced

6 If married, widowed, or divorced (or) WIFE of: Edith

7 DATE OF BIRTH (month, day, and year) Feb. 2, 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: works for himself

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lucinda Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of

(Address) Balto. City Hospitals

Filed ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10-30

17 I HEREBY CERTIFY, That I attended deceased from 7-9-30, 19..., to 9-10-30, 19...

that I last saw him alive on 9-10-30, 19...

and that death occurred, on the date stated above, at 1:15 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
Laennec type

(duration) ... yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jas Glendy Jr, M. D.

19 ... (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Sept 11 1930

20 UNDERTAKER: Samuel Stewesley

ADDRESS: 1728 Bolton

SEP 15 1930

C. HARRISON JONES, M. D.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60562

E 60562

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1413 Mosher St. 16-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Green

(a) Residence No. 1413 Mosher St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1860 Unknown

7-AGE, 70 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Easton Maryland

PARENTS.

10-NAME OF FATHER Levering Askins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland.

11- (Informant) Alberta Stevens,

(Address) 1413 Mosher St.

15- Filed P 15 1930 THOMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 12, 1930.

17- I HEREBY CERTIFY, That I attended deceased from April 5, 1928 to Sept. 11, 1930 that I last saw h[illegible] alive on Sept. 11, 1930 and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? Examination

(Signed) John D. Quinn, M. D.

9/12/30 (Address) 1507 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, June 14, 1930

20-UNDERTAKER Samuel Kennedy ADDRESS 1528 Mosher St.

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 60563

REGISTERED NO. E 60563

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 N. Washington ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret M. McKenney

(a) RESIDENCE NO. 528 N. Washington ST., 7 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Jame E. Mullen

DATE OF BIRTH (month, day, and year) Aug. 9. 1850

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	1	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md

10 NAME OF FATHER Peter Aydelotter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Mahalis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Mrs. Grace Deal

(Address) 528 N. Washington st

Filed SEP 15 1930, 19 HAMPSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13. 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1930, to Sept 12, 1930, that I last saw h. alive on Sept 12, 1930 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Pyonephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hunterian Lab.

(Signed) Frank Hayd, M. D.

Sept 14, 1930 (Address) 2026 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 16 1930
20 UNDERTAKER	ADDRESS
William G. Schaffer	1816 Monument

pec.—1-30—M. & T.—250 Bks

E 60564 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 60564

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Brookfield Av ST. 13-59 WARD)

2-FULL NAME Jacob L. Cohen

(a) RESIDENCE NO. 2117 Brookfield av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Cohen

DATE OF BIRTH (month, day, and year) May 23 1846

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	3	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Gen. Merchandise 045

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Phila Pa

10 NAME OF FATHER Lewis J. Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Annette Eyttinge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

PARENTS

14 Informant Samuel L. Cohen

(Address) 2117 Brookfield Ave

15 FILED SEP 15 1930 19 C. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14-1930

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to Sept 13, 1930, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B. Kaden, M. D.

, 19 (Address) 2306 Eutaw Pl,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cem.

UNDERTAKER Harid. Sondheim & Son

DATE OF BURIAL 9/16/1930

ADDRESS 1903 Eut Mad

pec.—1-30—M. & T.—250 Bks

60565

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60565

CERTIFICATE OF DEATH.

REGISTERED NO. 13-59

1-PLACE OF DEATH Lab Dunn's Pool Ro

CITY OF BALTIMORE: (No. Park Circle Apts. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leopold Ries

(a) RESIDENCE NO. Park Circle Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie A. Ries

DATE OF BIRTH (month, day, and year) May 7 1863

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	4	7	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ekhan Ries

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Weil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. A. Ries (Address) Park Circle Apts.

15 Filed SEP 15 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 1925 to Sept 14 1930, that I last saw him alive on Sept 14 1930, and that death occurred, on the date stated above, at 9 A. m. E. S. T.

The CAUSE OF DEATH* was as follows:

Coronary artery thrombosis: Angina pectoris

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: angina pectoris Symptoms (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — No —

What test confirmed diagnosis? —

(Signed) Louis P Hamburger M. D.

Sept 15, 1930 (Address) 1809 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Adath Israel Cem.

DATE OF BURIAL 9/16/1930

UNDERTAKER David Sondheim Son

ADDRESS 1732 Eutaw Place

pec.—1-30—M. & T.—250 Bks

E 60566 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 60566

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Linden ave ST. 14-20 WARD)

2-FULL NAME Mrs. Jenny Goldberg

(a) RESIDENCE NO. 2020 Linden ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Goldberg

7 DATE OF BIRTH (month, day, and year) July, 1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Philip Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Bertha Brian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Jacob Goldberg (Address) 2020 Linden Ave

15 Filed ....., 19.. [illegible] Registrar

1 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14th 1930 11:30 A m.

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to Sept. 14th, 1930, that I last saw h alive on Sept 14th, 1930, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of July 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surgical findings

(Signed) Michael B. Abrams, M. D.

9/14/, 1930. (Address) 2360 Eutaw place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 9/15/1930

20 UNDERTAKER David Sandler & Son

ADDRESS 1902 Eut

Spec.—1-10-21—M&T—1500 Bks.

E 60567.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60567.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2850 Clifton ave. WARD) 15-60

2-FULL NAME John Bradunas

(a) RESIDENCE NO. 2850 Clifton ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Bradunas

6 DATE OF BIRTH (month, day, and year) No. 1868

7 AGE 62 Years * Months ** Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) Lithvania (State or country)

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) Lithvania (State or country)

14 Informant Warren Walters

(Address) 2852 Clipton Ave.

15 Filed SEP 15 1930 HARRY JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to Sept. 13, 1930.

that I last saw him alive on Sept. 12, 1930,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) ... yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab. Findings

(Signed) John A. Buchness, M. D.

, 19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislowas — DATE OF BURIAL Sept. 16. 1930

20 UNDERTAKER John Greblauckas — ADDRESS 425 S Paca St

Spec.—1-30—M. & T.—250 Bks.

E 60568 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60568

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 849 Hollins ST. 14-29 WARD)

2-FULL NAME Stasis Gustaitis

(a) RESIDENCE No. 849 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

6 If married, widowed, or divorced HUSBAND) of or) WIFE of

7 DATE OF BIRTH (month, day, and year) Nov. 12, 1929

AGE Years 10 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stasis Gustaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Anne Pollenckas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant S. Gustaitis

(Address) 849 Hollins St.

15 Filed [illegible] 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-14-30

17 I HEREBY CERTIFY, That I attended deceased from aug 20, 1930, to July 13, 1930, that I last saw h alive on July, 1930, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

7, 14, 1930 (Address) 5[illegible] Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept. 16, 1930
UNDERTAKER	ADDRESS
John Greblianckas	423 S Paca St

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60569 — 1924 — 185 — E 60569

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No.) Maryland General Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James F Morris

(a) RESIDENCE NO. 501 F St, Sparrows Point. WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 5 yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) June 16, 1888

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	2	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Worker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Beth. Steel Corp. Cedar Grove N. C.

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER William Morris

11 BIRTHPLACE OF FATHER (city or town) North Carolina (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Heves

13 BIRTHPLACE OF MOTHER (city or town) North Carolina (State or country)

Informant Hospital Records

(Address)

Filed SEP 15 1930 C. Hampton Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept 14, 1930, that I last saw h im alive on Sept 14, 1930, and that death occurred, on the date stated above, at 12, noon m.

The CAUSE OF DEATH* was as follows:

Impacted Fract. 3rd Cervical Vert.

(duration) yrs. mos. 5 ds. (Primary)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Beth. Steel Corp. Sparrows Point

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray.

(Signed) Robert V. Cumming M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Melvale N. C. DATE OF BURIAL Sept 15 1930

0 UNDERTAKER M. W. E. Deppel Inc. ADDRESS 37 Saratoga

Spec.—1-30—M. & T.—250 Bks

0570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 11-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (NO. University Hospital 22-30 ST., WARD)

2-FULL NAME Louis Doerr

(a) RESIDENCE NO. 57 Northstrip Rd. Dundalk ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. 6 ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Bertha Doerr

7 DATE OF BIRTH (month, day, and year) Aug 10. 1890

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Sanitary Embalming Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisville Ky

PARENTS

10 NAME OF FATHER Henry Doerr
11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisville
12 MAIDEN NAME OF MOTHER Mary Bauer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisville

14 Informant Mrs Bertha Doerr
(Address) 57 North strip Rd. Dundalk Md.

15 FILED 5 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/8/30, 19 to 9/14/30, 19
that I last saw h[illegible] alive on 9/14/30, 19
and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:
Duodenal ulcer -

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intest. obstruction - (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home -
Did an operation precede death? Yes - Date of 9/9/30 - 9/10/30 -
Was there an autopsy? Yes -
What test confirmed diagnosis?
(Signed) George H. Gross -, M. D.
, 19 (Address) University Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louisville Ky
DATE OF BURIAL Sept 15 19 30

20 UNDERTAKER John Ulrich
ADDRESS 200 Eutaw

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60571 X 179 E 60571

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St Agnes Hospital 25-72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. T. Lacey Jr

(a) RESIDENCE NO. Catonsville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29-1922

7 AGE: Years 8 Months 5 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: na

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Jas. T Lacey Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER C J Flannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Jas T. Lacey Jr

(Address) Catonsville

Filed Sept 5 1930 C. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident. Clothes caught fire while playing in yard at Home

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Brooke, M. D. Coroner

Sept 2 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 9/16 1930

20 UNDERTAKER: H. C. Brownings Son

ADDRESS 1136 Poplar Grove St

Spec.—1-30—M. & T.—250 Bks.

E4 60572 E4 41

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 E 60572

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 17-26 WARD)

2-FULL NAME Herbert Wilson

(a) RESIDENCE No. 614 Bruns ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) May 26/29

AGE: Years _____ Months 15 Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Wilter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed 1 5 1930 19 HAMPSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 13/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to September 13, 1930, that I last saw h[illegible] alive on September 13, 1930, and that death occurred, on the date stated above, at 12 25 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) _____ yrs. _____ mos 12 da.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of _____

Was there an autopsy? Yes Autopsy findings

What test confirmed diagnosis? _____

(Signed) G. C. Goodwin M. D.

9/14/1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Sept 15, 1930

UNDERTAKER: Mrs Kate R Williams

ADDRESS 3222 Eutaw Pl

Spec.—1-30—M. & T.—250 Bks

E 60573 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60573

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 16-22 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME George Wm. Montgomery

(a) RESIDENCE NO. 1427 W. Lafayette ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year) Jan. 29, 1888

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paperhanger

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ellicott City Maryland

10 NAME OF FATHER George Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant Hospital Records

(Address)

15 FILED SEP 15 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1930, to Sept. 9, 1930, that I last saw him alive on Sept. 9, 1930, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) David Jenner, M. D.

9-10 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 9-15 1930

20 UNDERTAKER Daniel Taylor's

ADDRESS 916 Pa. ave

Spec.—12-5-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60574

CERTIFICATE OF DEATH.

90 E 60574

REGISTERED NO.

E 60574

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 Fulton Ave St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary E Grace

(a) RESIDENCE NO. Home for the aged of the M.E. Church Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 8 - 1846

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	83	11	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) Talbot County Md.

PARENTS

10 NAME OF FATHER Peter Grace

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Dyott

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Ella Conduit
(Address) 400 Fulton Ave

15 Filed 1 5 1930 19 By HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12. 1930

17 I HEREBY CERTIFY That I attended deceased from June 20 1930, to September 12, 1930, that I last saw h— alive on September 11, 1930, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Senile Exhaustion
(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? H
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical methods
(Signed) George L. Shannon, M. D.
12/13. 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Date of Burial Sept 15 1930

20 UNDERTAKER George J Smith ADDRESS Hollins

very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 60575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 E 60575

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hospital. St. 10-14 Ward)

2-FULL NAME John J. Cunabaugh

(a) RESIDENCE NO. # 1005 E. Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 6 mos. 24 dys. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucinda C. Cunabaugh.

6 DATE OF BIRTH (month, day, and year) February 21, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	6	24 23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Guard
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bartlett & Hayward C

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Denis Cunabaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary O'Brien.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Lucinda C. Cunabaugh
(Address) 1005 East Biddle St

15 Filed SEP 15 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept/14, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inquiry
Inquiry
Gun Shot wound
right side of head
Suicide Person

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1005 E. Biddle

Did an operation precede death? Date of

Was there an autopsy? History

What test confirmed diagnosis?

(Signed) G. C. Radcliffe, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Sept 17 1930

20 UNDERTAKER John F. Cowan & Son

ADDRESS 901 Hollins St

Important. See instructions on back of certificate.

Rec. 2-29-28—L. F. S.—500 Blks.

E 60576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 60576

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3123 Coldspring ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary J. Del Gavio

(a) RESIDENCE NO. 3123 Cold Spring Ave ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 40 mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Del Gavio

DATE OF BIRTH (month, day, and year) Nov 16 1876

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	9	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Pietro Maccola

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antonetta Papa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Antoinette De Pola

(Address) 3123 Cold Spring Ave

Filed SEP 17 1930, 19 Registrar

THOMPSON JONES M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12/30

17 I HEREBY CERTIFY, That I attended deceased from April 7. 1930, to Sept 12, 1930

that I last saw her alive on Sept 12, 1930

and that death occurred, on the date stated above, at 11-45 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilation.
(Chronic myocarditis)
Arterial Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James L Ashburst, M. D.

9-13 1930 Address 401 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Sept 16 1930

20 UNDERTAKER Frank V. Pikitone — ADDRESS 2815 E. Baltimore st

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60577

CERTIFICATE OF DEATH

90 E 60577

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 E. Lafayette Ave ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sadie F. Dorsey

(a) RESIDENCE NO. 113 E. Lafayette Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 1876.

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~House Keeper~~ Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) 048

(c) Name of employer

BIRTHPLACE (city or town) (State or country) West Virginia

10 NAME OF FATHER Dennis F. Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Agnes Bucking (Address) 113 E. Lafayette Ave.

15 Filed ... C. HAMPSON JONES, M. D. (Registrar)

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 13th Sept. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1930, to Sept 13, 1930, that I last saw h[illegible] alive on Sept 13, 1930 and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage (rt)

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis - arterio Sclerosis. (duration) 3 or 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) S A Dodds, M. D.

Sept 15, 1930 (Address) 317 Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 16, 1930
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W North Ave.

pec.—1-30—M. & T.—250 Bks

E 60578

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 60578

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 3-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Clay Lewis

(a) RESIDENCE NO. 320 S. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

6 If married, widowed, or divorced HUSBAND of or) WIFE of ?

7 DATE OF BIRTH (month, day, and year) ?

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records of

(Address) Balto. City Hosp.

Dec 5 1930 19 HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10-30

17 I HEREBY CERTIFY, That I attended deceased from 9-9-30, 19, to 9-10-30, 19,

that I last saw him alive on 9-10-30, 19,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chr & Acute

Syphilis, Tertiary

Unable to Obtain History (duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Sherwood Jr, M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS SEP 15 1930

pec.—1-30—M. & T.—250 Bks.

E 60579 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60579

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Harlem Ave ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Fowler

(a) RESIDENCE NO. 1510 Harlem Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Color Negro	Married

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 1855

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Saloon

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER William Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Elsie Roberts

(Address) 1510 Harlem Ave

15 FILED ..... 19 ..... THOMPSON JONES, M. D. Registrar

5-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1930, to Sept 15, 1930, that I last saw him alive on Sept. 14, 1930, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. S. Taylor M. D.

9/15, 1930 (Address) 1522 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rodgers Mass Sept 15 1930 DATE OF BURIAL

20 UNDERTAKER John E. Miller ADDRESS 2435 E Oliver

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60580

CERTIFICATE OF DEATH

23 V E 60580

REGISTERED NO. 24-33

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 1108 William ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Regina H. Armstrong.

(a) RESIDENCE NO. 1108 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 64 yrs. 11 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Armstrong.

DATE OF BIRTH (month, day, and year) Sept. 30, 1865.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64.	11.	14.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER James H. Armstrong.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del. City Del.

12 MAIDEN NAME OF MOTHER Mary Lloyd.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Bernard Armstrong.

(Address) 1108 William St.

C. HAMPSON JONES, M. D.

5 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/17/30.

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Sept 16 1930.

that I last saw her alive on Sept. 17, 1930.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Encephalitis (Epidemic).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hyde W. Dalley M. D.

, 19 (Address) 5-103 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem. DATE OF BURIAL Sept 17, 1930

20 UNDERTAKER A. Howard Edmondson ADDRESS 38 E. Fort Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60581 — 90 — E 60581

REGISTERED NO.

E 60581

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 E. North ave) (8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice M. Sickel

(a) RESIDENCE NO. 1509 E. North ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 6 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced — HUSBAND of (or) WIFE of: Edward Sickel

DATE OF BIRTH (month, day, and year): Mch 7. 1846

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	6	7,	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Herman Trust

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliz. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Geo H. Sickel

(Address) 3002 Creamore Ave

Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 12 — 1930, to Sept 14, 1930,

that I last saw her alive on Sept 13 — 1930, and that death occurred, on the date stated above, 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis 3 ds.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema Lungs (duration) 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. Gill Hall, M. D.

9-15. 1930 (Address) 1631 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount — DATE OF BURIAL: Sept 17 1930

20 UNDERTAKER: Chas O Mitchell & Son — ADDRESS: Eutaw Place

spec.—1-30—M. & T.—250 Bks. Jacob Fisher 1823 N. Washington st Vol 5130

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60582 90 E 60582

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 2313 Harford Ave (Street) 8-45 (Ward)

2-FULL NAME Elizabeth A. Foster

(a) RESIDENCE NO. 2313 Harford Ave St., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Married

6 If married, ~~widowed, or divorced~~
or) WIFE of Charles M. Foster

7 DATE OF BIRTH (month, day, and year) Oct 8th 1863

AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	66	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework Fam
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Stephen Taich
11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)
12 MAIDEN NAME OF MOTHER Augusta Kuhlman
13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Charles M. Foster
(Address) 2313 Harford Ave

15 Filed Sept 15 1930, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1928, to Sept 14, 1930.
that I last saw h alive on Sept 14, 1930,
and that death occurred, on the date stated above, at 10.55 A.m.
The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) 2 yrs. mos 10 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Jacob Fisher, M. D.
9/15, 1930 Address 1823 N. Wash. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 9/17/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

pec.—1-30—M. & T.—250 Bks. Dr. Miles Wheeler 2129 W. North Ave Taf 3232 ✓

E 60583

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60583

CERTIFICATE OF DEATH.

24-004

REGISTERED NO. 15-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2257 N. Fulton Ave ST.) (WARD)

2-FULL NAME John K. Faulstick

(a) RESIDENCE NO. 2257 N. Fulton Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, ~~widowed, or divorced~~ HUSBAND of ~~not WIFE of~~ Carrie Faulstick

7 DATE OF BIRTH (month, day, and year) March 4th 1848

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) R R Ofc

(c) Name of employer N. C. R. R. Shops

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. John Faulstick

(Address) 2257 N. Fulton Ave.

15 Filed Sept 15 1930 19 HARRY JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930, to Sept 14, 1930, that I last saw him alive on Sept 13, 1930 and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 21 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No General Symptoms

What test confirmed diagnosis?

(Signed) Edwin A. Pindell M. D.

Sept 15 19 30 (Address) 2129 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 9/16/1930

20 UNDERTAKER Wm Cook — ADDRESS 1219 St Paul St

1-30—M. & T.—100 B—50L

E 60584

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 V

E 60584

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) City Hospital ST. 70-69 WARD)

2-FULL NAME John Milton

(a) RESIDENCE NO 2207 Booth St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Henrietta Milton

6 DATE OF BIRTH (month, day, and year) Dec 26th 1849

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
80	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Ohio (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ohio (State or country)

14 Informant Sadie E Stouffer

(Address) 6521 Maplewood Ave Edgewood

15 FILED 5 1930 . 192 MARION JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2207 Booth St.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? History

(Signed) J. G. Eades, M. D. Coroner

19 (Address) 1436 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 9/16/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 Eutaw St

pec.—1-30—M. & T.—250 Bks

E 60585 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60585

CERTIFICATE OF DEATH. 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) City Hosp - 26-37 (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Prato.

(a) RESIDENCE NO. 639 Newkirk ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 8. 1910

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	9	5	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) Woodlawn Pa.
(State or country)

10 NAME OF FATHER Joseph Prato

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Penatta

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Hospital Records.
(Address)

Filed 5-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/13/30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1930, to Sept 13, 1930, that I last saw him alive on 9/13, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart Disease

(duration) 1 yrs. 9 mos 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Can't know

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

(Address) City Hosp -

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery St Paul

DATE OF BURIAL 9/16/1930

20 UNDERTAKER Wm Cook 1217 E Pratt St

ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 60586 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60586

CERTIFICATE OF DEATH.

REGISTERED NO. 73

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 13-51 ST., WARD)

2-FULL NAME Lawrence Kerr

(a) RESIDENCE NO. 97 Kelly Place ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Sept. 23, 1888

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	11	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Parkin Kerr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Gosnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records of Balto. City Hosp.

15 Filed 5-1930, 19 HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13-30

17 I HEREBY CERTIFY, That I attended deceased from 3-4-29, 19..., to 9-13-30, 19...

that I last saw him alive on 9-13-30, 19...

and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Lateral Sclerosis (Spastic Paraplegia) traumatic

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis & Pyelitis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Clinical

(Signed) Geo. Gosnell M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hompden DATE OF BURIAL 9/16 19 30

20 UNDERTAKER Wilhom Cook ADDRESS 1217 E Pratt St

I-80—M. & T.—100 B—50L

E 60587

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60587

CERTIFICATE OF DEATH

REGISTERED NO. X 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp ST. 25-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw. Vincent Hunt

(a) RESIDENCE NO 125 Smithwood ave ST., Catonsville 2nd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	6	10	16 15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm J Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lula J Pusch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm J Hunt

(Address) Catonsville

15 [illegible] 5 1930 [illegible] HAMPSON JONES M.D. (Registrar)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident - Clothes caught fire while playing in yard

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O. Wroe, M.D. Coroner

9/15, 1930 (Address) 3601 Third Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 9/16 1930

20 UNDERTAKER Geo. A. Wicke & Son

ADDRESS Edmondson

1-30—M. & T.—100 B—50L

E 60588

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60588

CERTIFICATE OF DEATH

REGISTERED NO. 185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) En route to University Hosp. (If not in hospital, give ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank A. Schmitt

(a) RESIDENCE NO 608 S. Macow ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Schmitt

6 DATE OF BIRTH (month, day, and year) Aug 17-1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38		25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Riveter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Md Dry Dock

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Schmitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katherine Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Margaret Schmitt

(Address) 608 S. Macow St

15 Filed ..... 192 ..... Registrar

5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull Accidental Death

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At work

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D. Coroner

Sept 14 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL 9/16 1930

20 UNDERTAKER Harry A. Wittke 4101

ADDRESS Edmondson Ave.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60589

CERTIFICATE OF DEATH

46 E 60589

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 330 S. Mount ST., 14-28 WARD)

2—FULL NAME Mary Blunt

(a) RESIDENCE NO. 330 S. Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Nathaniel Blunt

DATE OF BIRTH (month, day, and year) April 5, 1865

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	5	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Housework~~ At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Laurence Revell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret O'Donovan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Isabelle A. Stoffel

(Address) 133 S. East Ave.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 4th, 1930, to Sept 13th, 1930, that I last saw h[illegible] alive on Sept 13th, 1930 and that death occurred, on the date stated above, at 10 35 P. m.

The CAUSE OF DEATH* was as follows:

Myocardiosclerosis

Probably (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) [illegible] M. D.

, 19 (Address) 1901 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 9/17/30

20 UNDERTAKER Geo. A. Curtis, 1101

ADDRESS Edmondson

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60590

E 60590

CERTIFICATE OF DEATH.

REGISTERED NO. 1-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Sinai Hosp. ST. 25-77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rose Debtula (née Martuszewski)

(a) RESIDENCE NO. 1620 Church ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Philip Debtula

DATE OF BIRTH (month, day, and year) Feb. 16. 1913

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	7	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Paul Martuszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Lucy Guzik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mrs. Martuszewski 1620 Church St.

15 SEP 26 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-4-30, 19..., to 9-15, 1930.

that I last saw her alive on 9-15-, 1930,

and that death occurred, on the date stated above, at 2:30 P.m. E.S.T.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) ...yrs. mos 22 ds.

CONTRIBUTORY (Secondary) None

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Melton B Kersh M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem.

DATE OF BURIAL Sept 18 1930

20 UNDERTAKER Margaret D. Flynn

ADDRESS 1122 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

Dr. Davidson
3132 Poulwood

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60591

CERTIFICATE OF DEATH

E 60591

1—PLACE OF DEATH

REGISTERED NO. 8-40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3239 Elmley Ave ST. WARD)

2—FULL NAME Anna Kroegen

(a) RESIDENCE NO. 3239 Elmley Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

If married, widowed, or divorced ~~HUSBAND of~~ WIFE of John Henry Kroegen

DATE OF BIRTH (month, day, and year) June 5th 1870

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	3	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Christian Kromelbein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant John Henry Kroegen

(Address) 3239 Elmley Ave

Filed 9 1930 19 HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-14-30

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to Sept 14, 1930, that I last saw her alive on Sept 13, 1930 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) H. J Davidson, M. D.

19 (Address) 303 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Violettsville, Md	9/18/ 1930

20 UNDERTAKER Geo. Weber & Son

ADDRESS 2503 Edmondson Ave

Spec. 2-29-28—L. F. S.—500 Bks.

E 60592 E60592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 60592

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Washington Blvd. ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose L. P. Mitchell

(a) RESIDENCE NO. 1112 Washington Blvd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of George Mitchell

7 DATE OF BIRTH (month, day, and year) Jan. 4, 1873

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	8	11	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Boston, Mass.

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

Informant George Mitchell

(Address) 1112 Washington Blvd.

Filed SEP 16 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1926, to Sept 15, 1930, that I last saw her alive on Sept 15, 1930 and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis, Intestinal Obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical

(Signed) J. M. Dellett, M. D.

Sept 16, 1930 (Address) 621 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Sept 17 1930
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

pec.—1-30—M. & T.—250 Bks. E60593.

240611
60593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 181-082 60593

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE, (No. ..... ST., 7-9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Lackett

(a) RESIDENCE NO. 339 St Paul Place ST., ... WARD Pawhatan Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 11 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Single

a If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Dec-29-1915

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	14	8	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N W

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Naomi Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed 1-6 1930 Jos. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-14-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1930, to Sept 14, 1930

that I last saw her alive on Sept 14, 1930

and that death occurred, on the date stated above, at 10 55 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Anaesthesia - Nitrous oxide.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes. Date of 9-14-30.

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) E. B. Harrison Jr., M. D.

9/15, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL 9-16 1930

UNDERTAKER Reuel Eaton

ADDRESS 916 Ba

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60594 — 188-703 — E 60594

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Fund. Hosp St., (E. or W. Ward) 19-27

2-FULL NAME Jas A McCubbin

(a) RESIDENCE NO. 224 Norris St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanora McCubbin

6 DATE OF BIRTH (month, day, and year) Feb 26 — 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Edw McCubbin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wash D C

12 MAIDEN NAME OF MOTHER Martha Keller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wash D C

14 Informant Eleanora McCubbin
(Address) 224 E Norris St

Filed 6 1930 19 [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto truck in which he was riding overturned

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Femur

Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ford'k Rd Nr Ellicott City

Did an operation precede death? No Date of

Was there an autopsy? Yes Pm & Clinical

What test confirmed diagnosis? X Ray

(Signed) [illegible] M. D.

9/15 1930 (Address) 29 E 33rd St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Sept 17th 1930

20 UNDERTAKER A. Jones

ADDRESS 111 S Gilmor

Spec.—1-30—M. & T.—250 Bks

60595 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 60595

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals ST 13-54 WARD

REGISTERED NO. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. _____ ST _____ WARD _____

2-FULL NAME Fred Geweken

(a) RESIDENCE NO. 2724 Parkwood Ave. ST., _____ WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of or) WIFE of Sarah M. Geweken

DATE OF BIRTH (month, day, and year) 1872 - Sept 10th

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58 ~~57~~		3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman United Ry 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER ~~Unknown~~ Henry Geweken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Unknown~~ Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of (Address) Balto. City Hosp.

Filed SEP 16 1930 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13-30

17 I HEREBY CERTIFY, That I attended deceased from 6-3-25, 19 ... to 9-13-30, 19 ..., that I last saw him alive on 9-13-30, 19 ..., and that death occurred, on the date stated above, at 3:45 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia, left
Cerebral Hemorrhage, rt
Myocarditis, Chronic

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of _____

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) Fred Geweken M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept. 17 1930

UNDERTAKER Philip Herrig — ADDRESS 2016 Orleans St

Spec.-7-17-26—A Co.—200 Bks.

E 60596

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60596

CERTIFICATE OF DEATH

REGISTERED NO. 49

1-PLACE OF DEATH

City of BALTIMORE: (No. 140 Jefferson St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Broxton

(a) RESIDENCE NO. 1407 Jefferson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Steve Broxton

6 DATE OF BIRTH (month, day, and year) Aug 22 / 1908

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	22		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. Carolina

(State or country)

PARENTS

10 NAME OF FATHER Martin Williams

11 BIRTHPLACE OF FATHER (City or town) N. Carolina

(State or country)

12 MAIDEN NAME OF MOTHER Mame Boyd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Robt Montgomery

(Address) 3614 Ronaldson Va.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 / 30 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept 15, 1930, that I last saw h alive on Sept 14, 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Carcinoma of Larynx

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? not known

Did an operation precede death? None Date of

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) Richard L Eastwick, M. D.

, 19 (Address) 1514 E Baltimore

*State the Disease Causing Death, or in deaths From Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Point Comfort Va

Date of Burial Sept 18 1930

20 UNDERTAKER Edward Broxton

ADDRESS [redacted] 91 orchard

1-30—M. & T.—100 B—50L

E 60597

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60597

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5 D Bethel ST., 34 WARD)

2-FULL NAME Rose Broom

(a) RESIDENCE NO 5 D Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) V.a

PARENTS

10 NAME OF FATHER David Red

11 BIRTHPLACE OF FATHER (city or town) (State or country) V.a

12 MAIDEN NAME OF MOTHER un known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) un known

14 Informant Josphine Barber
(Address) 20 N. dallas st

15 Filed ..... 192 ..... Registrar

P 16 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) A C Blade, M. D. Coroner

, 19 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery

DATE OF BURIAL sept 17 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

pec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

0598

CERTIFICATE OF DEATH

129 E 60598

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 209 E 20 1/2 ST. 12-19 WARD)

2—FULL NAME Mary C Smith

(a) RESIDENCE NO. 209 E 20 1/2 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1867

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah A Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Clinton J Smith

(Address) 1341 W Mount St

Registered ... 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to Sept. 13, 1930, that I last saw h[illegible] alive on Sept. 10 1930 and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel C Wolfe, M. D.

9/15, 1930 (Address) 1331 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 9/16/30

20 UNDERTAKER Samuel B Humphrey & W Biddle

ADDRESS 578

1-30—M. & T.—100 B—50L

60599

HEALTH DEPARTMENT—CITY OF BALTIMORE

70 2 W E 60599

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) Lafayette Hospital ST., K 6 WARD)

2-FULL NAME Adam M. Sands

(a) RESIDENCE NO. 2625 Hudson ST., 1 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Attendant at
(b) General nature of industry, business, or establishment in which employed (or employer) School
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ida R. Nesbonsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant James H. Sands (Father)
(Address) 2625 Hudson St

Filed P 1 6 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Was Playing at night ran and pushed same through glass door

(duration) yrs. mos 4 hrs

CONTRIBUTORY (Secondary) Accid

(duration) yrs. mos. 4 ds. Hrs

18 Where was disease contracted if not at place of death? 2625 Hudson

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Autopsy

(Signed) H. C. Hades, M. D. Coroner

19 (Address) 142 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL Sept 17 1930

20 UNDERTAKER Lilly & Julian Sue

ADDRESS 40 S. Wood St

ec.—2-29-28—L. F. S.—500 Bks.

60600

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 60600

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 20-28

CITY OF BALTIMORE: (No. 2007 Wilkins ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Simon Seldetz

(a) RESIDENCE NO. 2007 Wilkins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Seldetz

DATE OF BIRTH (month, day, and year): 1874

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Zalig Seldetz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Minnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: Mrs Sarah Seldetz

(Address) 2007 Wilkins ave

Filed SEP 16 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/16/30

17

I HEREBY CERTIFY, That I attended deceased from 9/10, 1930, to 9/16, 1930, that I last saw h[illegible] alive on 9/15, 1930 and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? h

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D Abraham, M. D.

9/16 1930 (Address) 172 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd

DATE OF BURIAL: Sept 16 1930

20 UNDERTAKER: S Levinson Bro

ADDRESS 1121 E Balto St

pec.—1-30—M. & T.—250 Bks.

E 6060] HEALTH DEPARTMENT—CITY OF BALTIMORE [E 6060

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3905 Falls Road ST., 13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Riley

(a) RESIDENCE NO. 3905 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of Alexander Riley

DATE OF BIRTH (month, day, and year) Dec. 24-1882

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	8	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Carrie Riley

(Address) 2033 Woodberry Ave

15 Filed OCT 6 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14-1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 10th, 1930, to Sept 14th, 1930, that I last saw her alive on Sept 14th, 1930, and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows: Acute dilatation of Heart

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings.

(Signed) E. O. Tillett, M. D.

9/15/1930 (Address) 3614 Falls Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL Sept. 17- 1930.

20 UNDERTAKER Horace F. Burgee ADDRESS 1231 Falls Road

pec.—8-16-29—L. F. S.—100 Bks.

E 60602 HEALTH DEPARTMENT—CITY OF BALTIMORE 16 602 E 60602

CERTIFICATE OF DEATH

REGISTERED NO. 10-13

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1437 Webb ST., WARD)

2—FULL NAME Kate Harrity

(a) RESIDENCE NO. 1437 Webb ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Tom. Harrity

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Samuel Clayton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Mollock

(Address) 1423 Rockeby St.

15 Filed 16 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13-30

17 I HEREBY CERTIFY, That I attended deceased from Sep 8, 1930, to Sep 12, 1930, that I last saw her alive on Sep 12 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Medical

(Signed) R. H. Walters, M. D.

, 19 (Address) 1445 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL Sept. 16 1930

20 UNDERTAKER Chas. H. Johnson

ADDRESS 446 N. Caroline St.

-30—M. & T.—100 B—50L

E 60603

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60603

CERTIFICATE OF DEATH

194

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) City Hospital ST. 3-4 WARD)

2-FULL NAME James Bradley

(a) RESIDENCE NO. 1507 Gough ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Weatherboy
(b) General nature of industry, business, or establishment in which employed (or employer) Stone Works
(c) Name of employer

9 BIRTHPLACE (city or town) Pittsburgh
(State or country) S. Carolina

PARENTS

10 NAME OF FATHER James Bradley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER James Hinton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. Carolina

14 Informant Lilly Howard

(Address) 1507 Gough St

15 SEP 16 1930 CLAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted if not at place of death? Bond Steel Foundry

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Geo. Glades, M. D.
Coroner

, 19 (Address) 143 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Sept. 7 1930

20 UNDERTAKER Wm. Lee & D'Epee

ADDRESS 300 S. Eden

pec.—1-30—M. & T.—250 Bks

E 60604

E 60604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 2-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Junior Franczszowski

(a) RESIDENCE NO. 724 S. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) May 2, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Walter Franczszowski

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Mannus

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14 Informant Walter Franczszowski

(Address) 724 S. Durham St.

Filed SEP 16 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1930, to Sept 15, 1930, that I last saw him alive on Sept 15, 1930, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wylie M. Farr, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL Sept 16 1930.

ADDRESS

UNDERTAKER Harold L. Rippel

ADDRESS 3004 Eden

...ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60605

CERTIFICATE OF DEATH.

31 E 60605

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 760 W Mulberry ST. 17-76 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Taylor

(a) RESIDENCE NO. 760 W Mulberry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 24, 1907

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
22	8	20	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Robert Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Gertrude Carver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Gertrude Taylor
(Address) 1106 Druid Hill Ave

Filed 1 5 1930 19 ... JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Sept 13, 1930, that I last saw her alive on Sept 6, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Howell M. D.

19 (Address) 601 N Carrollton Ave

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Lancaster & Va

DATE OF BURIAL Sept 16 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania ave.

...cc.—1-30—M. & T.—250 Bks

60606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90 E 60606

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 4-25 ST., WARD)

2-FULL NAME James J. Healy

(a) RESIDENCE NO. 324 N. Greene ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of -

DATE OF BIRTH (month, day, and year) Oct. 27, 1873

AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	56	10	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher and salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

BIRTHPLACE (city or town) London

(State or country) England

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Ann Whalen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 19 HARRISON JONES, M. D. Registrar

16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14-30

17 I HEREBY CERTIFY, That I attended deceased from 9-12-30, 19, to 9-14-30, 19,

that I last saw him alive on 9-14-30, 19,

and that death occurred, on the date stated above, at 8:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Coronary Occlusion

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. Shmoel Jr., M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Green Cemetery

DATE OF BURIAL 9/17/30, 19

20 UNDERTAKER George J. Duffy Sons

ADDRESS 1730 Harford

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60607

CERTIFICATE OF DEATH.

91-002

E 60607

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 941 N. Bond ST. 7-13 (WARD)

2-FULL NAME John E. Hagerty

(a) RESIDENCE NO. 941 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Christina Hagerty

DATE OF BIRTH (month, day, and year) July 21 1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	76	1	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) New York

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Christina Hagerty (Address) 941 N. Bond St

15 Filed SEP 16 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/15/30

17 I HEREBY CERTIFY, That I attended deceased from June 6th, 1930 to Sept 15th, 1930

that I last saw him alive on Sept 10th, 1930

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cerebro Vascular Accident

(duration) 3 mo. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Harrison Jones M. D.

19 (Address) 1490 Del Roar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Sept 18, 1930
UNDERTAKER	ADDRESS
Henry Storck Sons Inc.	130 E Eager St

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60608 | 129 E 60608

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Sinai Hospital ST. 6-10 WARD)

2-FULL NAME Mrs Ella Berman

(a) RESIDENCE NO. 2210 E Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3 If married, widowed, or divorced HUSBAND of or) WIFE of David Berman

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Nachaul Lahowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lutia Frah-

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

PARENTS

14 Informant (Address) I. Lewis 1434 E. Balto St

15 Filed SEP 6 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/15/30.

17 I HEREBY CERTIFY, That I attended deceased from 9/11, 1930, to 9/15, 1930, that I last saw her alive on 9/15/30, 19..., and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine analysis.

(Signed) Milton B. Cook M.D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel | DATE OF BURIAL 9-16- 1930

20 UNDERTAKER I Jacob Lewis, 1434 E Balto St | ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60609 — 129 ✓ — × E 60609

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (NO. Caton & Wilkens Aves ST. 25-W WARD)

2-FULL NAME Sister Mary Catherine Fallon

(a) RESIDENCE NO. Maryknoll, Ossining N.Y. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female — 4 COLOR OR RACE white — 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11 1864

7 AGE 65 Years — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maryknoll Sister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER Unk-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant. Mother Mary Joseph (Address) Maryknoll, Ossining N.Y.

15 6 1930 [illegible] JUNE 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16— 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-16 1930, to 9-16 1930, that I last saw her alive on 9-16 1930, and that death occurred, on the date stated above, at 1 05 P m. Standard

The CAUSE OF DEATH* was as follows:
Chronic Hypertension Cardio-Vascular Renal Disease.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplectic Stroke (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Sign

(Signed) Robert Hewer, M. D.

19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ossining N.Y. — DATE OF BURIAL Sept 16 1930

UNDERTAKER John O'Neill & Son — ADDRESS 190 Lafayette Place

pec.—1-30—M. & T.—250 Bks

E 60610 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60610

46

CERTIFICATE OF DEATH.

REGISTERED NO. 7-48

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Dora W. Wilhelm

(a) RESIDENCE NO. 5304 Ready Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White.	Single.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Single

DATE OF BIRTH (month, day, and year) Nov 24, 1895.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
34		9	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Fred Wilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jena Biermuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Heidtzel (Address) 5304 Ready Ave

15 SEP 6 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from ~~August~~ 20, 1930 to Sept 15, 1930, that I last saw h[illegible] alive on Sept 15, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma

(duration) ?, yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Ovary

(duration) ?, yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 27, 1930.

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic exam of Biopsy

(Signed) Michael Greenfield, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Sept 17, 1930

20 UNDERTAKER John Ulrich

ADDRESS 2108 Arlington

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60611

E 60611

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No.) Marlborough Apts. 4 D. 1701 Eutaw Place. St. (Ward) 14-30

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Schwab

(a) RESIDENCE NO. Marlborough Apts. St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Sept. 20th. 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Groceries
(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Schwab
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bavaria
12 MAIDEN NAME OF MOTHER Henrietta Strauss
13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant
(Address) Marlborough Apts.

15 [illegible] 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, au-
topsy or inquiry.) find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Injury) Broken Compensation
(Duration) yrs. mos. ds.

Sept 16 1930 (Signed) H C Blades M. D.
(Coroner)
, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cheb Shalom Cem. Date of Burial 9/17/ 1930

20 UNDERTAKER Harris Sondheimer ADDRESS 1902 Eutaw Place

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60612

CERTIFICATE OF DEATH

74-001

E 60612

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp St, 2nd Ward)

2-FULL NAME Zydor Mark

(a) RESIDENCE NO. 1503 Nelson Ct St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 50 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER John Mark

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Andy Mark
(Address) 207 E Chester St

15 Filed ..... 19.. HAMPSON JONES, Registrar

6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Disease. Lung
Lesion Hemorrhage
(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Emphysema
(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What confirmed diagnosis? Autopsy

(Signed) Fred A Stahr M. D.

19 (Address) 1536 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sept 17 1930

20 UNDERTAKER: J W Bazkowski, Eastern Ave — ADDRESS 1930

Rec. 2-29-28—L. F. S.—500 Blks.

E 60613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 60613

REGISTERED NO.

1—PLACE OF DEATH: Maryland General Hosp.

CITY OF BALTIMORE: (No.) Madison (Street) (WARD) 17-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: Mr Irvin Muller

(a) RESIDENCE NO. 2520 Maryland Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Irvin Muller

DATE OF BIRTH (month, day, and year): Aug. 14, 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: Phillip Henry Mueller Md

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Hospital records

(Address):

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930, to Sept 14, 1930, that I last saw h[illegible] alive on Sept 14, 1930 and that death occurred, on the date stated above, at 11:50 m. Stand. T.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert H. Clements, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

20 UNDERTAKER: Wm Cook

DATE OF BURIAL: 8/17 1930

ADDRESS: 1217 E Pool St

EARSON JONES, M.

6 1930

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60614

E 60614

48

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) NO. 1313 Clarkson ST. 43-31 WARD)

2-FULL NAME Philip Jos. Schaeffer

(a) RESIDENCE NO. 1313 Clarkson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write this word): Widowed

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Annie E. Schaeffer

6 DATE OF BIRTH (month, day, and year) Apr. 28, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boss

(b) General nature of industry, business, or establishment in which employed (or employer): Stable

(c) Name of employer: Swindell Bros.

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Lenora Jones

(Address) 1313 Clarkson st.

15 Filed 9 19 30 CLARKSON JONES M.D., Registrar

6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1929, to Sept. 15, 1930, that I last saw him alive on Sept. 15, 1930 and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Arteio-Sclerosis and carcinoma of face

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. S. T. Campbell M.D.

9/15 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: 9/17 1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St. Paul St.

Dec.—1-30—M. & T.—250 Blks.

Dr Thos Mungatroyd
25 Barclay

60615 HEALTH DEPARTMENT—CITY OF BALTIMORE 128 E 60615

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 442 E 115 & 28th St 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J Dawson

(a) RESIDENCE NO. 442 East 28th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced (a) HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Oct 1872

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	11		

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Wm Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Emma Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant Lottie Burton

(Address) 442 East 28½ St.

15 Filed 6 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 9th, 1930, to Sept 14th, 1930, that I last saw h[illegible] alive on Sept 14th, 1930, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Dr Mungatroyd M. D.

9/16 1930 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 9/17 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

pec.—1-30—M. & T.—250 Bks.

E 60616

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60616

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 12-43 WARD)

2-FULL NAME Richard Montague

(a) RESIDENCE NO. 3801 Northern Parkway ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Louise M. Montague

DATE OF BIRTH (month, day, and year) Sept. 21 1890

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39 yrs.	11	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Frank L. Montague

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Caroline Kahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Louise M. Montague (Address) 3801 Northern Parkway

15 Rec'd 1930 By EDWARD JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16/30.

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1930, to Sept 16, 1930.

that I last saw him alive on Sept 16, 1930.

and that death occurred, on the date stated above, at 5 35 0 m.

The CAUSE OF DEATH* was as follows:

Grave Pneumonia

Appendicitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pyaemia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 10, 1930.

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Wm. Turnbull Hagerty M. D.

, 19 (Address) 22 Joseph Hagerty

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Sept. 17 1930

ADDRESS Gwynn Oak

20 UNDERTAKER Frank Lusby's Sons

(ec. 2-29-28—L. P. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60617 ✓ E 60617

E 60617

CERTIFICATE OF DEATH

REGISTERED NO. 15-62 47

1—PLACE OF DEATH 3300 Kate Ave. corner Reisterst. & Road (If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ST., WARD)

2—FULL NAME Catherine S. Mohler,

(a) RESIDENCE NO. 3300 Kate Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

If married, widowed, or divorced
HUSBAND of (or) WIFE of Clarence W. Mohler

DATE OF BIRTH (month, day, and year) August 29, 1866

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64		18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Edmond H. Stubbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Farrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Samuel J. Stubbs,

(Address) 3300 Kate Avenue

Filed ..... 19..... Registrar

6-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15 1929 to Sept. 16 1930

that I last saw her alive on Sept. 16 1930

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of left Mamma with metastases to left lung.

(duratinn) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease cnntracted if not at place of death?

Did an operation precede death? Date of Sept 1929.

Was there an autopsy? No

What test cnnfirmed diagnosis? Clinical.

(Signed) James S. Ashhurst M. D.

9-16 1930 (Address) 401 2 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Sept. 18, 1930

20 UNDERTAKER E. Leroy Stiffler & Inc.

ADDRESS 125 E. Northave.

pec.—1-30—M. & T.—250 Bks

E 60618

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60618

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. W-30 WARD)

2-FULL NAME Daniel Dawson.

(a) RESIDENCE NO. Ellicott City Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy B Dawson

DATE OF BIRTH (month, day, and year) Jan. 1, 1878

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	8	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland.

10 NAME OF FATHER Owen Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daisy B Dawson (Address) Ellicott City

15 [illegible] 19[illegible] Registrar

6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1930, to Sept 16th, 1930, that I last saw him alive on Sept 16th, 1930, and that death occurred, on the date stated above, at 3:00 P m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis - Hypertension - Myocardial insufficiency - Cardiac Hypertrophy & Dilatation - Chronic Endocarditis (duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (Complication) Myocardial insufficiency, (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy - Laboratory

(Signed) J H Schoolman, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Good Shepherd Cem.

DATE OF BURIAL 9-19 1930

20 UNDERTAKER J.D. Montgomery Jr

ADDRESS Ellicott City Md

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

60619 — 33 E 60619

CERTIFICATE OF DEATH.

REGISTERED NO. 1724

1-PLACE OF DEATH
CITY OF BALTIMORE: (a) No. 731 Dolphin St. 17 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lois Fisher

(a) RESIDENCE NO. 731 Dolphin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 15 - 1918

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	10	28	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) 000
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Leroy Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Gladys Custis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Gladys Fisher
(Address) 731 Dolphin St

15 Filed 1-7 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept 13, 1930, that I last saw h[illegible] alive on Sept 13, 1930, and that death occurred, on the date stated above, at 905 P m.

The CAUSE OF DEATH* was as follows:

1 B G Peritonitis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. R. Beasley, M. D.
, 19 (Address) 754 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt auburn

DATE OF BURIAL Sept 17 1930

UNDERTAKER Jos H Tradin

ADDRESS 1027 Hanover Ave

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 60620

CERTIFICATE OF DEATH.

60620

1-PLACE OF DEATH Baltimore City Hosp. 23-31 ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Richard Elings

(a) RESIDENCE NO. 180 Hamburg ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced (HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) -1906

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Richard Elings

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Maggie Smothers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed SEP 17 1930 H. LESLIE JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930. to Sept 13, 1930.

that I last saw h~~im~~ alive on Sept 13, 1930.

and that death occurred, on the date stated above, at 4.15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

Unknown (duration) yrs. mos ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clynical

(Signed) David Tenner M. D.

9-13, 1930 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 17 1930

UNDERTAKER John H. Joachim

ADDRESS 1027 Lund Ave

pec.—1-30—M. & T.—250 Bks.

(Leyden)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60621

100-001

E 60621

CERTIFICATE OF DEATH.

REGISTERED NO._____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 5 WARD)

2-FULL NAME Gladys Leyden (Leyden)

(a) RESIDENCE No. 1145 19 Fayette ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

If married, widowed, or divorced
HUSBAND of
or) WIFE of —

DATE OF BIRTH (month, day, and year) 1930

AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
		7		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Norman Leyden

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Gladys Keen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Gladys Leyden

(Address) 1145 E Fayette St

Filed 1 7 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930, to Sept 16, 1930, that I last saw h[illegible] alive on Sept 16, 1930, and that death occurred, on the date stated above, at 10:35 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Terminal)

(duration) ____ yrs. ____ mos 3 ds.

CONTRIBUTORY (Secondary) Malnutrition Dc-
hydration (duration) ____ yrs. ____ mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL osbury cemetery — DATE OF BURIAL Sep 18 19 30

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

pec.—1-30—M. & T.—250 Bks

E 60622

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60622

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 N. Fulton Ave ST.) 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hezekiah Peter Shultz

(a) RESIDENCE No. 1612 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Lenora M. Shultz

DATE OF BIRTH (month, day, and year) June 7-1845

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	3	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Carroll Co Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ##

14 Informant Robert L. Shultz (Address) 1612 N. Fulton Ave

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14-1930

I HEREBY CERTIFY, That I attended deceased from Dec, 19 29, to Sept 14, 19 30,

that I last saw h— alive on Sept 13 19 30,

and that death occurred, on the date stated above, at 6 55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 10 mos da.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 10 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Geo. M. Kieffer, M. D.

Sept 16, 19 30 (Address) 20 S. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL Sept 17 19 30

20 UNDERTAKER Wm. J. Tickner & Son ADDRESS N. Y & Pa

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60623 E 60623

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Gibson

(a) RESIDENCE NO. Holland Point ST., ... WARD ..... Calvert Co. Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. I mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	✓

6 If married, widowed, or divorced HUSBAND of or) WIFE of ✓

DATE OF BIRTH (month, day, and year) July 5 1924

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	I	2	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

10 NAME OF FATHER Geo. Gibson

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country)

12 MAIDEN NAME OF MOTHER Lillian Caulk

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Mrs Caulk (Address) 114 E Biddle St

15 Filed SEP 17 1930 [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1930, to Sept 16, 1930, that I last saw him alive on Sept 16, 1930, and that death occurred, on the date stated above, at 11.24 A.m.

The CAUSE OF DEATH* was as follows:

Child admitted to hospital in a bad state of malnutrition of few wks duration

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. M. Barnes Anderson, M. D.

9/16, 1930 (Address) Mercy Hospital City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Co Md. DATE OF BURIAL Sept 18 1930

UNDERTAKER Wm Cook ADDRESS St Paul & Preston

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60624

101-001 E 60624

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 404 S. Paca St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jokubaitis

(a) RESIDENCE NO. 404 S. Paca St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1875

7 AGE 55 Years * Months * Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labar 40

(b) General nature of industry, business, or establishment in which employed (or employer) City Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania

(State or country)

PARENTS

10 NAME OF FATHER NO.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Lithvania

12 MAIDEN NAME OF MOTHER NO.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithvania

14 Informant J. Jokubaitis

(Address) 714 W Lombard St.

Filed SEP 17 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12 1930 to Sept. 15 1930, that I last saw h[illegible] alive on Sept. 15 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John B. Meadowship M. D.

9/16 1930 (Address) 642 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer Sept. 18. 1930

20 UNDERTAKER — ADDRESS

John Grebliauckas 423 S Paca St

1-30—M. & T.—100 B—50L

60625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1885 E 60625

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 26-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Miller

(a) RESIDENCE NO 3221 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Miller

6 DATE OF BIRTH (month, day, and year) Oct 17/1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Jno. Geblein Packing House

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia Miller

(Address) 3221 McElderry St

15 Filed SEP 17 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

(accidently slipped on greasy object in yard 700 n. Castle St)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fractured left femur at hip-Sep 9/30 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Geblein Packing House 700 n. Castle St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. H. Breitenbach, M. D. Coroner

9/16/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem

DATE OF BURIAL 9/17/30

20 UNDERTAKER Geo. Lenhardt

ADDRESS 525 N. Lyndale Ave

Dec.—1-30—M. & T.—250 Bks.

40366 60626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 60626

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) (Street) (Ward) 16-33

2-FULL NAME Mary Smith

(a) RESIDENCE NO. 1832 W. Lafayette Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6 If married, widowed, or divorced (HUSBAND of) or) WIFE of Clarence

DATE OF BIRTH (month, day, and year) ——1890

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) D of Columbia

10 NAME OF FATHER John Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md—

12 MAIDEN NAME OF MOTHER Rosa Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

PARENTS

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed SEP 17 1930 H. L. Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 13/30

17 I HEREBY CERTIFY, That I attended deceased from September 13, 1930, to September 13, 1930, that I last saw her alive on September 13, 1930, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Myomata uteri. Syphilis (Wassermann Reaction) Secondary Anemia Cerebral Hemorrhage

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) W. S. Everett, M. D.

9/13, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Sept 17 1930

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pierstman St

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2406627 E 60627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSP... REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 14-20 WARD)

2-FULL NAME Cecil W. Smith

(a) RESIDENCE NO. 403 Robert- ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 2 - 1927

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3		13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0-0

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Robert- Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Lucille Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed 1-7 1930 19 ... Ralph Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-15-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept-14 , 1930 , to Sept 15 , 1930 ,
that I last saw h[illegible]alive on Sept 15 , 1930 ,
and that death occurred, on the date stated above, at 10 50 P m.

The CAUSE OF DEATH* was as follows:
Septicemia - organism unidentified -

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of no
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs.
(Signed) W C Hagerty , M. D.
Sept 6 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 17 1930

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1803 Orleans

1-30—M. & T.—100 B—50L

E 60628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101001

E 60628

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST. 16-22 (WARD)

2-FULL NAME Richard Boyer

(a) RESIDENCE NO 1513 Laurens ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10/1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eleanor Ringgold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ernst Boyer
(Address) 1513 Laurens St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 15/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said his (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? yes at St Joseph Hospital

What test confirmed diagnosis? autopsy

(Signed) [signature] Coroner, M. D.

9.16.1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 9/18 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

1-30—M. & T.—100 B—50L

E 60629

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60629

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 16-22 WARD)

2-FULL NAME Mabel Green

(a) RESIDENCE NO 1134 Calhoun ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER Lee Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Julia Green

(Address) 1134 Calhoun St

15 Filed P 17 1930 C. HERBERT JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubo - ovarian disease

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 9/13/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Eugene A Kelly Coroner, M. D.

9/17, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Albion

DATE OF BURIAL 9/17 1930

20 UNDERTAKER Daniel Easters

ADDRESS 416 Penna Ave

Misc.—1-30—M. & T.—250 Bks.

E 60630

E 60630 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. ..... ST. 4 E 25th (D)

2-FULL NAME Colbern Houston

(a) RESIDENCE NO. 713 South Ann ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Blk	Widowed

6 If married, widowed, or divorced HUSBAND of (or WIFE of) Gladys Houston

DATE OF BIRTH (month, day, and year) 1886

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Alabama

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) do

12 MAIDEN NAME OF MOTHER do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do

14 Informant Baltimore City Hosp.

(Address) .....

15 Filed 1-7 1930 H. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1930, to Sept 15, 1930

that I last saw him alive on Sept 14, 1930

and that death occurred, on the date stated above, at 12 15 m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Empyema

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Hosp

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Surgical

(Signed) Harry G. Clement M. D.

9/15/30 (Address) Balt City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 9-17 1930

20 UNDERTAKER Daniel Easton

ADDRESS 916 Penna ave

Spec.—1-30—M. & T.—250 Bks

E 60631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 60631

REGISTERED NO. 15-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4007 Fernhill Ave WARD

2-FULL NAME Frank B. Nachman

(a) RESIDENCE NO. 4007 Fernhill Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE Miriam S. Nachman

DATE OF BIRTH (month, day, and year) June 25, 1875

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	55	7	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ft. Balto. Md.

10 NAME OF FATHER Henry Nachman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mina Hirsman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. F. B. Nachman

(Address) 4007 Fernhill Ave

15 Filed 1 7 1930 19 C. Hilleary Jones, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16/30.

17 I HEREBY CERTIFY, That I attended deceased from Apr, 1930, to Sept 16, 1930, that I last saw h-- alive on Sept 16, 1930 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) A. C. Smith, M. D.

19 (Address) 4509 Liberty Hgts. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem.

DATE OF BURIAL 9/18/1930

20 UNDERTAKER Harold Sondheimer Son

ADDRESS 1902 Eutaw Place

Dec.—1-30—M. & T.—250 Bks.

E 60632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 60632

REGISTERED NO. 13-59

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2317 McCulloh ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie R. Sartar

(a) RESIDENCE NO. 2317 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col-	Widow

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1850

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

BIRTHPLACE (city or town) St Louis Mo
(State or country)

10 NAME OF FATHER Wm Spencer

11 BIRTHPLACE OF FATHER (city or town) Mo
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Lane

13 BIRTHPLACE OF MOTHER (city or town) Mo
(State or country)

Informant Robert Sartar
(Address) 2317 McCulloh

FILED 9 17 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 11 — 1930 to Sept 14 — 1930.

that I last saw h[illegible] alive on Sept 13 — 1930

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bain M. D.

9/17 1930 Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft Auburn

DATE OF BURIAL 9/19 1930

20 UNDERTAKER Samuel J Kennedy

ADDRESS 758 Bid

pec.—1-30—M. & T.—250 Bks

60633

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 E 60633

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Church ST. 23-27 WARD

2-FULL NAME Edward Kolodnicki

(a) RESIDENCE NO. 1619 Church ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) 7/22/29

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Theodore Kolodnicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia Kaczara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Julia Kolodnicki

(Address) 1619 Church St

15 Filed 7-1930 H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1930 to Sept 16, 1930

that I last saw h[illegible] alive on Sept 14, 1930

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Eastern Shore Md.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ellen D. Storey M. D.

(Address) 4700 Pennington Sept 16 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL 9/17 1930

20 UNDERTAKER Wm Fiaschowski

ADDRESS 1618 Eastern Ave.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60634 ✓ 124 E 60634

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 10-14 WARD)

2-FULL NAME John Wroe

(a) RESIDENCE NO. Preston + Valley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of .....

DATE OF BIRTH (month, day, and year) Oct 15th 1842

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
87	88	10	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Wroe

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER Martha Barr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Little Sisters of the Poor (Address) Preston + Valley

15 Filed SEP 17 1930 E. L. [illegible] JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 16, 1930, that I last saw h[im] alive on Sept 15, 1930, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chr. Nephritis & arteriosclerosis (duration) unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Physical Exam.

(Signed) Wm. K. Geraghty M. D.

9/17/30 19 (Address) 2225 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Sept 17 1930

20 UNDERTAKER Paul Mudefield

ADDRESS 914 Greenmount Ave

ec.—2-29-28—L. F. S.—500 Bks.

E 60635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

52 ✓ E 60635

REGISTERED NO.

1—PLACE OF DEATH
ITY OF BALTIMORE (No. 1305 E. Biddle ST. 8-12 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Fisher

(a) RESIDENCE NO. 1305 E. Biddle ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
ength of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Fisher

DATE OF BIRTH (month, day, and year) Feb 29-1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	17	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Balto Md
(State or country)

10 NAME OF FATHER Henry Hamm

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Goblein

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant Miss Nora Fisher
(Address) 1305 E Biddle St.

Filed ..., 19.. H. LLOYD JONES, M. D.
Registrar

17 1935

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 30

17 I HEREBY CERTIFY That I attended deceased from November 1, 1916 to Sept 16, 1930.

that I last saw h.. alive on Sept 16, 1930

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Paralysis

CONTRIBUTORY (Secondary) Arthritis Deformans (duration) yrs. mos. ds.

(duration) 14 yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Signs

What test confirmed diagnosis?

(Signed) A. E. Hertzler, M. D.

Sept 16, 1930 (Address) 1301 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery DATE OF BURIAL Sept 18 30

20 UNDERTAKER Reitamel & Yoe ADDRESS 1723 N Lafayette Ave

Spec.—1-10-21—M&T—1500 Bks.

E 60636

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 60636

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 N. Fort Ave. ST. 23-31 WARD)

2-FULL NAME Louis Wagner.

(a) RESIDENCE NO. 122 N. Fort Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. ---- ds. How long in U. S., if of foreign birth? 60 yrs ---- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of ~~XXXXXXX~~ Mary E. Wagner.

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired watchman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER William Wagner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Christina Reinhardt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary E. Wagner. (wife)

(Address) 122 N. Fort Ave.

15 Filed ... 1930 ... C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to September 14, 1930.

that I last saw him alive on September 14, 1930

and that death occurred, on the date stated above, at 8. p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

Arterio sclerosis.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M. Reinhardt, M. D.

9/15, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL 9-17 1930

20 UNDERTAKER Stewart Mortuary Co ADDRESS Balto.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60637

CERTIFICATE OF DEATH

182

E 60637

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 118 S Wolfe st. St., 24 Ward)

2-FULL NAME Margaret Bialek

(a) RESIDENCE NO. 118 S. Wolfe street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10- 1929.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	3	6.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Bialek

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Bronislava Sobus.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Bronislava Bialek
(Address) 118 S Wolfe street

15 Filed ..... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows: Acc Drowning, fell in 5 gal bucket with bottle playing

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? History

(Signed) C. E. Cades, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cemetery	Sept 18 1930
20 UNDERTAKER	ADDRESS
George A. Weber	705 S. Amity

Rec. 2-29-28—L. F. S.—500 Bks.

E 60638

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60638

CERTIFICATE OF DEATH

113

1—PLACE OF DEATH Md. Gen. Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose Marie Cook

(a) RESIDENCE NO. 2531 Fait Ave ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1/30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9 months	9		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Jack J. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lottie Bigdol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.J. N.J.

Informant Hosp. Records

(Address)

Filed 1 7 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-21-, 1930, to 9-16-, 1930, that I last saw her alive on 9-16-, 1930 and that death occurred, on the date stated above, at 5.55 P.m. Std

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Clin. Lab.

(Signed) Robert V. Cornwell, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 9/17 1930

20 UNDERTAKER John J Fahey Sons

ADDRESS 1318 Light

pec.—1-30—M. & T.—250 Bks

E 60639 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60639

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Rammes.

(a) RESIDENCE NO. 3239 Chestnut ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 27/74

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) New York

10 NAME OF FATHER John Rammes

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Alice Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Hospital Records.

(Address)

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17/30

17 I HEREBY CERTIFY, That I attended deceased from 9-11, 1930, to 9-17, 1930, that I last saw him alive on 9-17, 1930, and that death occurred, on the date stated above, at 6 25 A m.

The CAUSE OF DEATH* was as follows:

Advanced carcinoma of stomach with positive Wassermann.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical.

(Signed) H M Baumgartner, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville Md.

DATE OF BURIAL Sept 21 1930

20 UNDERTAKER Francis Flaherty Son

ADDRESS Rockville Md.

Spec.—1-10-21—M&T—1500 Blks.

Louisa Jones ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60640

E 60640

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1838 E. Lafayette Ave., City St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Jones

1a) RESIDENCE NO. 1838 E. Lafayette Ave., City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Clay Jones

6 DATE OF BIRTH (month, day, and year) July 12, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Christopher C. Fairbanks

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Drusilla Stocksdale

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Maryland

14 Informant Mr. Edward Brown,
(Address) 1838 E. Lafayette Ave., City

15 Filed 7 1930, 19 JAMES JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from April, 1925, to September 16, 1930,

that I last saw her alive on September 13, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the breast

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of the mediastinum

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Overlea, Md.

Did an operation precede death? Yes Date of Oct. 1928

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson M. D.

(Address) 9/17/30 A. L. Wilkinson, 5713 Belair Rd., Rosedale, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 19 1930

20 UNDERTAKER Myers & Sons — ADDRESS 41 & W Broadway

1-30—M. & T.—100 B—50L

E 60641

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60641

CERTIFICATE OF DEATH

185

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Paruch

(a) RESIDENCE NO 617 S. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2/25

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	8	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Detroit, Mich.

PARENTS

10 NAME OF FATHER John Paruch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Kantor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hazeltown, Pa.

14 Informant Anna Paruch

(Address) 617 S. Wolfe St

15 Filed 9/17, 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 16/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Compound Fracture of Skull- Fell from fence to Recreation Pier Broadway & Thames St. Accidental.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? as stated

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) , Coroner, M. D.

9/17/30, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL 9 19 30

ADDRESS

20 UNDERTAKER John McNeal

1-30—M. & T.—100 B—50L

E 60642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001 E 60642

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2712 Allendale ST. 15-61 (WARD)

2-FULL NAME Charles E Roberts

(a) RESIDENCE NO 2712 Allendale ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced (or) WIFE of HUSBAND) of Mary E Roberts

6 DATE OF BIRTH (month, day, and year) May 28 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fruit Packer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Maryland.

PARENTS

10 NAME OF FATHER George A Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Maryland

12 MAIDEN NAME OF MOTHER Ellen Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Maryland

14 Informant Miss Thelma Roberts

(Address) 2712 Allendale Road

15 Filed ..... 7 1930 ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide. Gas Poisoning H.W.

CONTRIBUTORY (Secondary) A Syphilis (duration) yrs. mos — ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) H G Slades Coroner, M. D.

, 19 (Address) 143 B Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Sept-19 1930

ADDRESS

20 UNDERTAKER Hughes Horan Inc 424 N Broadway

& T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

0643 162 E 60643

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

1. CITY OF BALTIMORE: (No.) 222 Jasper ST. 425 (WARD)

2. FULL NAME Constance M. Holley

(a) RESIDENCE NO. 222 Jasper ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Holley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Theresa Coldert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Holley

(Address) 222 Jasper St

15 Filed ..... 192 ..... Registrar

187930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Feltus, M. D.
Coroner

9/17 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvert Cem

DATE OF BURIAL Sept 18 1930

20 UNDERTAKER Chas H Alexander

ADDRESS 20 Gilmore

Dec.—1-30—M. & T.—250 Bks.

Was Bedroom 1001 N Fulton Ave

E 60644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60644

REGISTERED NO. 24001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 N. Lanvale ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Devan

(a) RESIDENCE NO. 1924 N. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of or) WIFE of Clara N. Devan

6 DATE OF BIRTH (month, day, and year) March 11 1847

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	6	5	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler 038

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

8 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Devan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clara N. Devan

(Address) 1924 N. Lanvale St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Sept 17, 1930, that I last saw h[illegible] alive on Sept 17, 1930, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy -

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Senility (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. J. Thomas Fulton M. D.

9/17 1930 (Address) 1001 N Fulton Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 9/18 1930

ADDRESS 217 E Saratoga St

20 UNDERTAKER W M Cook

SONES, M. D.

pec.—1-30—M. & T.—250 Bks

E 60645

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60645

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals ST. 26-37 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Charles F. Bell

(a) RESIDENCE NO. Balto. City Hosp. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Oct. 3, 1850

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	11	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dawson Co.

BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Clara Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-17-30

17 I HEREBY CERTIFY, That I attended deceased from 6-7-13, 19..., to 9-17-30, 19...,

that I last saw him alive on 9-17-30, 19...,

and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Senility

Myocarditis, Chr. & Acute

Carcinoma (duration) yrs. mos da.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Ghrodd M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL 9/19 1930

20 UNDERTAKER Holborn Cook

ADDRESS 1217 E. Pond St

pec.—1-30—M. & T.—250 Bks

E 60646

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60646

CERTIFICATE OF DEATH.

REGISTERED NO. 10781

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 3-S WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Reed

(a) RESIDENCE NO. 36 S. High ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie

7 DATE OF BIRTH (month, day, and year) Dec. 26, 1877

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Hiram F.

11 BIRTHPLACE OF FATHER (city or town) W. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Emmart

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed SEP 18 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-15-30

17 I HEREBY CERTIFY, That I attended deceased from 9-13-30, 19..., to 9-15-30, 19...

that I last saw h... alive on 9-15-30, 19...

and that death occurred, on the date stated above, at 9:55 P. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia —
Resolving

(duration) ... yrs. ... mos 1½ ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Sept 18 1930

DATE OF BURIAL

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

Spec.—1-10-21—M&T—1500 Blks.

E 60647. HEALTH DEPARTMENT—CITY OF BALTIMORE E 60647

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (NO.) 330 W. Lorraine Ave ST. 12-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Morgan

(a) RESIDENCE NO. 330 W Lorraine Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Morgan

6 DATE OF BIRTH (month, day, and year): Sept 1. 1846

7 AGE: Years 84 Months 0 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country): Nova Scotia

PARENTS

10 NAME OF FATHER: James Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Nova Scotia

12 MAIDEN NAME OF MOTHER: Catherine Dunby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Nova Scotia

14 Informant: John J Crawford (Address) 330 Lorraine Ave

15 Filed: AUG 18 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Sept. 16, 1930, that I last saw h alive on Sept 16, 1930, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis - arteriosclerosis - myocarditis ?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

C C. Neuralgia yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Fernando R. Nicholas M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: 9/19 1930

20 UNDERTAKER: J M Cook

ADDRESS: 1274 Pulaski

P 1 8 1930 R/K JONES, M. D. Registrar

pec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60648

CERTIFICATE OF DEATH.

159 E 60648

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hosp (ST.) 13-57 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Riley

(a) RESIDENCE NO. 1505 W. 36th st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced? (write the word)
Male	W Lite	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) June 13, 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) md.

10 NAME OF FATHER John Riley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Margaret Ruby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant John Riley 1505 W 36th st.
(Address)

15 Filed SEP 18 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-6, 19 30, to 9-17, 19 30, that I last saw h— alive on 9-17, 19 30, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? St Luke

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) N B Sundiff, M. D.

, 19 (Address) 22 Druid Hyde

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary Woodlawn — DATE OF BURIAL Sept 18 1930

20 UNDERTAKER Emanuel Solon — ADDRESS 3615 Eastern ave

Cor.—10-10-29—A Co.—100 Bks.

60649

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60649

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 148 N. Exeter St. St., 5-8 Ward)

2-FULL NAME Yette Epstein.

(a) RESIDENCE NO. 148 N. Exeter St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 50 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White.	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Elis Epstein.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	55	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER Isadore Simon.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Philip Lichtenstein. (son)
(Address) 148 N. Exeter St.

15 Filed ... 19... C. [illegible] JONES, M. D.
SEP 18 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 17, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency.
Acute dilatation of the heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Leo Hemhauld M. D.

9/17, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash Rd DATE OF BURIAL 9/18/30 19

20 UNDERTAKER Jack Lewis ADDRESS 1439-E Balto st

Dec.—1-30—M. & T.—250 Bks.

E 60650 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60650

CERTIFICATE OF DEATH. 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Reisterstown Rd ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Case Greenberg

(a) RESIDENCE NO. 2408 Reisterstown Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mendel Greenberg

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 Bath St

15 Dec. 1, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-17-30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 19.., to Sept 17, 19.., that I last saw h.. alive on Sept 17, 19.., and that death occurred, on the date stated above, at 5 H m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilation

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Winter, M. D.

9-19, 1930 (Address) 2324 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 9-18- 19 30

20 UNDERTAKER Jack Lewis, 1439 Eutaw St

ADDRESS

1 81930

Spec.—1-10-21—M&T—1500 Bks.

E 60651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 60651

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Christian St. S. 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Hermansdorfer

(a) RESIDENCE NO. 1923 Christian ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hermansdorfer

6 DATE OF BIRTH (month, day, and year) Jan. 10, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Almendinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Gottlieb J. Hermansdorfer (Address) 1923 Christian St.

15 Filed SEP 16 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 1930 to Sept 15 1930, that I last saw h[illegible] alive on Sept 10 1930, and that death occurred, on the date stated above, at 11 45 P m. D.S.T.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 3 yrs. mns ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Lemperin M. D.

9/16, 1930 Address 3405 Callaway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

UNDERTAKER Joseph L Cook

DATE OF BURIAL Sept 18 1930

ADDRESS 1003 West Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

E 60652 E 60652

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1826 Laurens ST. 16 72 WARD)

2-FULL NAME Isaac Simms

(a) RESIDENCE NO. 1826 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Mary Simms

6 DATE OF BIRTH (month, day, and year) Mar 28, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	43	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Molder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Wallace Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Booze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Simms

(Address) 1826 Laurens St

15 Filed SEP 3 1930, 19 H. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 1st, 1930, that I last saw h[illegible] alive on Sept 1st, 1930, and that death occurred, on the date stated above, at 11-50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

, 19 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Sept 3 1930

20 UNDERTAKER A R Brown & Son

ADDRESS 108 W. Mound

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60653 38E 60653

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals S. 16-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Francis Newman

(a) RESIDENCE NO. 817 Peble Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Newman

DATE OF BIRTH (month, day, and year) Feb. 15, 1845

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	7		

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed SEP 18 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-15-30

17 I HEREBY CERTIFY, That I attended deceased from 8-16-30, 19..., to 9-15-30, 19..., that I last saw h... alive on 9-15-30, 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Luetic aortitis & aortic insufficiency

Myocarditis, chronic

(duration) yrs. 11 mos ... ds.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Path.

(Signed) Jas. Sherwood Jr. M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct DATE OF BURIAL Sept 18 1930

20 UNDERTAKER J. R. Brown & Son ADDRESS 1031 W. Lombard St

SEP 18 1930 JAMES H. JONES, M.

pec.—1-30—M. & T.—250 Blks

E 60654

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60654

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST 2-4 (WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Annie Himmelheber

(a) RESIDENCE NO. 1624 Fleet st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (HUSBAND) of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1886

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) New York

(State or country) New York

10 NAME OF FATHER Harris Cohen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Lena ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Hospital Records

(Address) [illegible]

15 Filed 8-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1929 to Sept. 15, 1930,

that I last saw her alive on Sept. 15, 1930,

and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculsis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Lemmer M. D.

9-16, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's 5th. Ref. Church Cem.

DATE OF BURIAL Sept. 18, 1930

20 UNDERTAKER Henry Sander & Sons. Inc

ADDRESS Baltimore St. & Broadway

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 60655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 60655

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1116 Eltonhead St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Glenn

(a) RESIDENCE No. 1116 Eltonhead ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Glenn

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years: about 50; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Elenton N. C

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

PARENTS

14 Informant: Andrew Glenn (Address) 1116 Eltonhead St.

15 Filed ... 19... REGISTRAR JONES, M. D., Registrar

SEP 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Since June, 1930, to Sept 13, 1930.

that I last saw h... alive on Sept 14, 1930.

and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

2 do Rheumatism (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? L

Did an operation precede death? No Date of L

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 1117 N. Chester

Sept 13, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Sept 15 30

20 UNDERTAKER: Samuel D. Stansbury ADDRESS: 1118 Bidd St

Rec.—2-29-28—L. F. S.—500 Bks.

E 60656 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60656

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N. Linwood ST., 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank H. Gross

(a) RESIDENCE NO. 714 N. Linwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Gross

DATE OF BIRTH (month, day, and year) March 14/1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Conrad Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germ.

Informant Mrs. Cath. Gross

(Address) 714 N. Linwood

Filed JUL 8 1930, 19 Jos. J. Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11-30

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1930, to July 11, 1930, that I last saw h[illegible] alive on July 11, 1930, and that death occurred, on the date stated above, at 2:20 a.m.

THE CAUSE OF DEATH* was as follows: Carcinoma Gall-Bladder

Arteriosclerosis

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of [illegible] July 30

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

9/17 1930 Address 6004 Ritchie Hy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Sept. 12 1930

20 UNDERTAKER Jos. J. Kerr ADDRESS 1564 N. Linwood ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60657

CERTIFICATE OF DEATH

199 ✓ E 60657

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore Hos. St. 25-77 Ward)

2-FULL NAME Louis I Krausz

(a) RESIDENCE NO. 1305 Cambria St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hazie O. Krausz

6 DATE OF BIRTH (month, day, and year) Feb. 10 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	39	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George L. Krausz

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Anna R. Rathell

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Krausz
(Address) 1305 Cambria St

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

While walking on dirt shoulder of road was struck and thrown down by Auto driven by a hit & run driver

(Duration) ... yrs. ... mos. ... ds.

(H) CONTRIBUTORY (Secondary) Fract C.C. Fork R & L Tibia & Fibula with second injury

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Patapsco Ave & 9th

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X-Ray

(Signed) [illegible] M. D.

9/17 1930 (Address) 3939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 9/18 1930

20 UNDERTAKER J. Fenw M. Cully

ADDRESS 130 E. Fort

pec.—1-30—M. & T.—250 Bks.

60658 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 60658

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2003 Hanover ST., (or) WARD)

2-FULL NAME Dennis C. Mardy

(a) RESIDENCE NO. 2003 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Jennie Mardy

DATE OF BIRTH (month, day, and year) September 1866

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jennie Mardy
(Address) 2003 Hanover St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to Sept 15, 1930, that I last saw him alive on Sept 15, 1930, and that death occurred, on the date stated above, at 12:45 Noon m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Asthma (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam

(Signed) J. D. Abell, M. D.

19 (Address) 1246 E 30th St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Sept 18, 1930

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1725 Eutaw Ave

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 E 60659

CERTIFICATE OF DEATH

60659

1—PLACE OF DEATH Md. Gen. Hospital REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST. 15-21 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Streb

(a) RESIDENCE NO. 2063 Walbrook ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) May 27, 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Charles J. Streb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nellie Minnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hosp. Records

(Address) .....

Filed ..... 19 ..... Registrar

1 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-15-, 1930, to 9-17-, 1930, that I last saw h.. alive on 9-17-, 1930 and that death occurred, on the date stated above, at 8:22 a.m.

The CAUSE OF DEATH* was as follows:

Ent. Gastro-enteritis

(duration) yrs. mos. 6 Wks ds.

CONTRIBUTORY (Secondary) Mongolism

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Hereditary + at home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert L. Clements M. D.

19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

20 UNDERTAKER J. F. M. Cully

DATE OF BURIAL 9/19 1930

ADDRESS 130 E Fort

pec.—1-30—M. & T.—250 Bks

E 60660 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60660

CERTIFICATE OF DEATH.

REGISTERED NO. 15-66

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4001 Ridgewood ave ST., WARD)

2-FULL NAME James F. Thompson Jr

(a) RESIDENCE NO. 4001 Ridgewood ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6 If married, widowed, or divorced (HUSBAND of or) WIFE of Nellie Sites Thompson

DATE OF BIRTH (month, day, and year) April 16 1890

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	√	1	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Schloss Bros

8 BIRTHPLACE (city or town) (State or country) Martinsburg West Virginia

10 NAME OF FATHER James F Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Martinsburg W. Va

12 MAIDEN NAME OF MOTHER Minna Ray

13 BIRTHPLACE OF MOTHER (State or country) Shepherdstown W. Va

PARENTS

14 Informant Nellie Sites Thompson
(Address) 4001 Ridgewood ave

15 FILED 19 JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/17/30

17 I HEREBY CERTIFY, That I attended deceased from July 27 1929 to Sept 17 1930, that I last saw h alive on Sept 17 1930, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Malignant neoplasm of bladder

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Cystoscopic exam

(Signed) A Goldstein, M. D.

19 (Address) Med. Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg W. Va

DATE OF BURIAL 9. 18 19 30

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. Fourth ave

FILED 9 18 1930

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60661

CERTIFICATE OF DEATH.

90 E 60661

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. St. Bluy 6-9 WARD)

2-FULL NAME Mrs Emma Barnard

(a) RESIDENCE NO. Church Home and Inf. ST. Bluy WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced [redacted] of Wm Theodore Barnard

DATE OF BIRTH (month, day, and year) Jan. 19, 1850

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80		7	29	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Invalid in Church Home for 5 years.

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Louis Thomas

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D. C.

12 MAIDEN NAME OF MOTHER Mary Curtis (Lewis)

13 BIRTHPLACE OF MOTHER (city or town) (Unknown) (State or country) Virginia

14 Informant Mrs James Dellard - daughter

(Address) Barnard House, Deerfield, Mass.

15 Filed [illegible] 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1930, to September 17, 1930, that I last saw her alive on Sept. 17, 1930, and that death occurred, on the date stated above, at 9:50 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (hypostatic)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Auscultation, percussion

(Signed) Oscar E Hubbard, M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenfield Mass.

DATE OF BURIAL 9/14 1930.

20 UNDERTAKER Hughes & Jones Inc

ADDRESS 4th & Broadway

pec.—1-30—M. & T.—250 Bks.

E 60662

E 60662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 2742 Maryland ST., 12-31 WARD)

2-FULL NAME Margaret Ann Gaddess

(a) RESIDENCE NO. 2742 Maryland St., WARD

(1)Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W.	Married

6 If married, widowed, or divorced (HUSBAND of or) WIFE of John B Gaddess

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
74				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Work 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs A J Gaddess (Address) 2742 Maryland a.

Filed SEP 18 1930 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16/30

17 I HEREBY CERTIFY, That I attended deceased from 9/16/20 . 19 . to 9/16/30 . 19 . that I last saw h.er alive on 9/16/30 . 19 . and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nefritis.

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Gaddess M. D.

9/23, 19 (Address) 321 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Sept 19 1930

20 UNDERTAKER Geo M. Fink & Son

ADDRESS 811 N Wolfe

pec.—1-30—M. & T.—250 Bks.

E 60663 ✓ E 60663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. North Broadway ST. 6-9 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MESSIX, John H

(a) RESIDENCE NO. BAY STREET, EASTON, MD ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ MARGARET MESSIX

7 DATE OF BIRTH (month, day, and year) 1874

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Ice Cream Plant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Centerville, Md (Near)

PARENTS

10 NAME OF FATHER George Messix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Kahall.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant MESSIX, John Mrs.
(Address) Easton Md.

Filed SEP 18 1930 C. THOMSON JOBES, Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 18th, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 1st, 1930, to September 18th, 1930,
that I last saw him alive on September 18th, 1930,
and that death occurred, on the date stated above, at 6.00 a.m. EST
The CAUSE OF DEATH* was as follows:
Cardiac and circulatory failure (Acute)
3 hours
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Scleroderma (universal)
(duration) Not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Palpation of skin
(Signed) Oscar E Hubbard, M. D.
, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md.
DATE OF BURIAL Sept 18 1930

UNDERTAKER Henry W. Measston
ADDRESS 801 N. Calvert

pec.—1-30—M. & T.—250 Bks.

740682
E 60664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 60664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Merr

(a) RESIDENCE NO. Portsmouth Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

a If married, widowed, or divorced HUSBAND of or) WIFE of Rebecca

DATE OF BIRTH (month, day, and year) 1884

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Moses Merr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 19 1930 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-18-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Sept 18, 1930, that I last saw him alive on Sept 18, 1930, and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Brain Tumor Malignant

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-12-30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ports mouth, Va.

DATE OF BURIAL 9-18-1930

UNDERTAKER Jack Lewis, 1439 E Balto

ADDRESS

Dec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60665 E 60665 129

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hosp ST., 1420 WARD

2-FULL NAME James Tilghman

(a) RESIDENCE NO. 1712 Madison Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	M

6 If married, widowed, or divorced HUSBAND of or) WIFE of Betty

DATE OF BIRTH (month, day, and year) May 2 - 1870

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	4	15	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter (P)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Eliza Smallwood

13 BIRTHPLACE OF MOTHER (city or town) md

(State or country)

14 Informant Betty Tilghman

(Address) 1712 Madison Ave

15 Filed 8-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-17-30

17 I HEREBY CERTIFY, That I attended deceased from 9-13, 1930, to 9-17, 1930,

that I last saw h.. alive on 9-17-30, 19...,

and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical.

(Signed) W. Hendrix, M. D.

9-17, 1930 (Address) St. Joseph Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 9-21-1930

20 UNDERTAKER Wm. H. Chase & Son

ADDRESS 1731 Madison Ave

pec.—1-30—M. & T.—250 Bks.

E 60666 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60666

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1413 Argyle (St.) (Ward) 24-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jones

(a) RESIDENCE NO. 1413 Argyle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C.	Widower

6 If married, widowed, or divorced (a) HUSBAND of or (b) WIFE of Theresa Jones

7 DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Public

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C. ?

12 MAIDEN NAME OF MOTHER Jones ?

13 BIRTHPLACE OF MOTHER (City or town) (State or country) N. C.

14 Informant William A. Jones (Address) 1202 Argyle

Filed SEP 18 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11/30

17 I HEREBY CERTIFY, That I attended deceased from 9/7, 1930, to 9/11/30, that I last saw h alive on 9/10, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus ?

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Chi, M. D.

(Address) 1202 Argyle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

SEP 18 1930

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Argyle ST., _____ WARD)

2-FULL NAME William H. Jones

(a) RESIDENCE NO. 1423 Argyle ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Sim Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Wm. Jones

(Address) 1423 Argyle Ave

15

Filed _____, 192 _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Diarrhoea

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _____ Coroner, M. D.

19 (Address) 436 Murray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL _____ 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL
SEP 18 193
Commissioner Health

TO THE MORGUE

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-09 60667

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
OF BALTIMORE Fall 227 W Mulberry ST. 425 (WARD)

2-FULL NAME Alexander Jaggetto

(a) RESIDENCE NO. Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: about 50 — Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ?
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Provident Hosp Record
(Address)

15 Filed ....., 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 8th 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. Hours

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Sept 9th Herbert Corner, M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

JOHNS HOPKINS HOSPITAL
SEP 10 1930
MORGUE

C. ... Commissioner Health.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60668

CERTIFICATE OF DEATH

E 60668

118-09

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hospitals St., 16-37 Ward)

2-FULL NAME Samuel Taylor

(a) RESIDENCE NO. Unknown St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Strangulation of Cause
Tonsils
undetermined (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fulton, M. D.

9/4, 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS
	SEP 16 1930

SEP 16 1930

THE MONOUR

Cor.—10-10-29—A Co.—100 Bks.

E 60669

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 60669

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St., 16-37 Ward)

2-FULL NAME Bertha Faiton

(a) RESIDENCE NO. unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Randolph Faiton

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	about 25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) unknown
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant .....
(Address) .....

Filed SEP 18 1930 C. ELLISON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Wood alcoholism

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

9.10.1930 (Address) 707 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side foc additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 18 1930

20 UNDERTAKER Commissioner Health

ADDRESS

Date ... Wm. E. WOODALL

THE MORGUE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60670

E 60670

CERTIFICATE OF DEATH.

90

REGISTERED NO. 11-24

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 1318 Linden Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Derr.

(a) RESIDENCE. NO. 1318 Linden Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Mathilda S. Derr.

6 DATE OF BIRTH (month, day, and year): Feb 15 1844

7 AGE: Years 86 Months 7 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Druggist

(b) General nature of industry, business, or establishment in which employed (or employer): Tinware Mfg.

(c) Name of employer: Matthai Bros.

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Mathilda Derr.

15 Filed AUG 8 1930 E. HAMPSON JONES, M. D. Registrar By RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17 1930

17 I HEREBY CERTIFY, That I attended deceased from ~~Sept~~ August. 1928. to Sept. 18. 1930.

that I last saw him alive on Sept. 17. 1930.

and that death occurred, on the date stated above, at 12.10 A. m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral insufficiency — Myocardial Degen. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Michel, M. D.

Sept 15 1930 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Sept 22 1930

20 UNDERTAKER: Chas. E. Franck — ADDRESS: 802 Madison Ave

Spec.—1-30—M. & T.—250 Bks.

E 60671 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60671

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Sinai Hospital ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Bricko

(a) RESIDENCE NO. 3 N. Glover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) Jan 27-1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER John Bricko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Gitina Korzeniowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

PARENTS

14 Informant John Bricko (Address) 3 N. Glover St.

15 Filed 9 1930 19 HT Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1930, to Sept. 17, 1930, that I last saw her alive on Sept. 17, 1930, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
Type undetermined

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Survey (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at home - 3 N. Glover

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) Melton Blenksh M. D.

9/17, 1930 (Address) Dun 1405P

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 9/17 1930

20 UNDERTAKER Wm. Fiaskowski — ADDRESS 1618 Eastern Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60672

90 E 60672

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Aged Womens Home

City of BALTIMORE: (No. 1404 W Lexington St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emma M Miller

(a) RESIDENCE NO. 1404 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10, 1858

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	72	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Miss E M Turlington

(Address) 1404 W Lexington St

15 Filed 19

Registrar RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19 27, to Sept. 18, 1930

that I last saw h alive on Sept. 2, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows: Acute Cardiac Dilatation

(duration) yrs. mos. da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin C Jarrell M. D.

19 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial Sept 19 1930

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins

Very important. See instructions on back of certificate.

1930

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60673

CERTIFICATE OF DEATH.

129 E 60673

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 400 Fulton Ave (St.) 30-37 (Ward)

2-FULL NAME Miss Laura Ray.

(a) RESIDENCE NO. Home for the Aged of the M.E. Church (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred all of life How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 17 - 1849

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	81	3	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ✓

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Ray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Easton Md.

12 MAIDEN NAME OF MOTHER Drusanah Bottfield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Easton Md.

14 Informant Miss E. Ella Lowndes

(Address) 400 N. Fulton Ave

15 Filed ..... 19 ..... Registrar

8 1930 RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1930

17 I HEREBY CERTIFY, That I attended deceased from June 12 1930, to Sept 17, 1930, that I last saw h[illegible] alive on Sept 16, 1930, and that death occurred, on the date stated above, at 2. a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) 7 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) Geo. C. Shannon, M. D.

9/17, 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial Sept 17 1930

20 UNDERTAKER George F. Smith ADDRESS 1532 Pulaski

rec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 60674

E 60674 REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 433 Evesham Ave ST., 27-58 WARD

2—FULL NAME Charles B Edwards

(a) RESIDENCE NO. 433 Evesham Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced
BUSBAND of
(or) WIFE of Laura E Edwards

DATE OF BIRTH (month, day, and year) 9-31-1861

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	27½	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md
(State or country)

10 NAME OF FATHER Chas E Edwards

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Sanford

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

Informant Mrs Mary Edwards
(Address) 433 Evesham Ave

Filed 1 0 19?? 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1930, to Sept 16, 1930, that I last saw h[illegible] alive on Sept 16, 1930, and that death occurred, on the date stated above, at 4 A- m.

The CAUSE OF DEATH* was as follows:
Anuselems, Chr Myocarditis
Hypertrophic arterial Sclerosis
Endocardial Chr

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arth Cardiac debility (duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Indgt

(Signed) S. L. Hopkins, M. D.

9/17 1930 (Address) 501 Aberdeen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Sept 19 1930

20 UNDERTAKER Mary Mc Woodfield — ADDRESS 501 E 22d St

pec.—1-30—M. & T.—250 Bks.

E 60675 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60675

CERTIFICATE OF DEATH. 717

REGISTERED NO. ____

1-PLACE OF DEATH Rt Jones Rd & Belair Rd (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4107 St., Ward)

2-FULL NAME Melva Farrar

(a) RESIDENCE NO. Harford Rd & 2nd ave WARD Carney Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Jan. 19, 1928

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	8	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James A. Farrar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James T. Farrar (Address) 2nd ave & Harford Rd

15 Filed 8 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18-30

17 I HEREBY CERTIFY, That I attended deceased from 9-17-30, 19..., to 9-18-30, 19...

that I last saw h-e alive on 9-18-30 19...

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Appendicitis Acute Diffuse Peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 9/19/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Hendley, M. D.

, 19 (Address) 1st Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL 9/22 19 30.

20 UNDERTAKER Harry V. Deitzler

ADDRESS 121 Edmondson Ave.

1-30—M. & T.—100 B—50L

E 60676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9-41

74-001 E 60676

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Gorsuch Ave ST. ..... WARD)

2-FULL NAME Emma T. Baker

(a) RESIDENCE NO 615 Gorsuch Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work File Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U.S.F. & G. Co

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John W. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah E. Wright

13 BIRTHPLACE OF MOTHER (City or town) Balto Md. (State or country)

14 Informant Sara E. Baker (sister)

(Address) Halethorpe, Md.

15 Filed ..... 1930 ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 17/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs ..... mos 3 hrs ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. H. Collins, M. D. Coroner

9/18/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cemetery

DATE OF BURIAL 9/19/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 S. Paul St

pec.—1-30—M. & T.—250 Bks.

Dr Niblett 2220 Garrison Ave

E 60677 HEALTH DEPARTMENT—CITY OF BALTIMORE 60677

CERTIFICATE OF DEATH.

REGISTERED NO. 65

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Hilton Court Apartments ST. 15 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernhard A Block

(a) RESIDENCE NO. Hilton Court Apartment ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of Abbie E Block

7 DATE OF BIRTH (month, day, and year) Dec 24 1877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Book Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 009
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Edward Block

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Dallam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Abbie E Block
(Address) Hilton Court Apts

15 Filed AUG 8 1930, 19 U. S. PUBLIC HEALTH SERVICE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from
Aug 14, 1930, to Sept 17, 1930,
that I last saw him alive on Sept 16, 1930
and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Hodgkins disease
from history (duration) about yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? — Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory

(Signed) Walter S Niblett M. D.
Sept 17 1930 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 9/19 1930

20 UNDERTAKER Wilson Cook

ADDRESS 1217 N Eutaw St

Dec.—2-29-28—L. F. S.—500 Bks.

E 60678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 60678

REGISTERED NO.

1—PLACE OF DEATH
(a) CITY OF BALTIMORE (or) 3345 Belvidere Ave ST., 27-56 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E Croggon

(a) RESIDENCE NO. 3345 Belvidere Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) May 25-1870

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	22	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Washington D C

10 NAME OF FATHER William E Croggon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington

12 MAIDEN NAME OF MOTHER Cordelia E Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Mrs. Croggon
(Address) 3345 Belvidere Ave

Filed ..., 19...

C. HARRY WILLIAMS, M. D.
Registrar

15 1930 Mar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, (to) Sept 17/30, 1930, that I last saw h... alive on Sept 17/30, 1930, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary) Cardiac Hypertrophy (duration) 6 yrs. mos. ds.

a Arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. Carroll M. D.

19 (Address) 5912 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL Sept 19 1930

20 UNDERTAKER H. S. Marshall ADDRESS 353 Fall Rd

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60679 90 E 60679

E 60679

REGISTERED NO. 2755

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3911 Haywood WARD)

2—FULL NAME Mrs Margaret L. Langford ST. Langford

(a) RESIDENCE NO. 3911 Haywood ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Jas W Langford

DATE OF BIRTH (month, day, and year) Feb 7, 1852

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	7	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None - lived with her children

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Frederick Albright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frankfort-on-Main Germany

12 MAIDEN NAME OF MOTHER: Margaret Anne Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Md.

Informant: Nellis L. Langford

(Address) 3911 N. Haywood Ave.

Filed ... 19... C. JEFFERSON JONES, M. D. Registrar

8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-17-30

17 I HEREBY CERTIFY, That I attended deceased from May, 1930, to Sept 17th, 1930, that I last saw her alive on Sept 15th, 1930 and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Chron Mitral Endocarditis

Chronic Myocarditis (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Physical Exam

(Signed) C. D. Surratt, M. D.

9-17-1930 (Address) 4936 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY — DATE OF BURIAL: Sept 20th 1930

20 UNDERTAKER: J. B. Shipley — ADDRESS: 856 W. Baltimore St.

pec.—1-30—M. & T.—250 Bks.

E 60680

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60680

CERTIFICATE OF DEATH.

123

REGISTERED NO. 20-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 430 S. Smallwood St. (WARD) 20-69

2-FULL NAME George H. Hefflin

(a) RESIDENCE NO. 430 S. Smallwood St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth B. Hefflin

DATE OF BIRTH (month, day, and year) Sept 16 1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	1	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Carl Hefflin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth B. Hefflin (Address) 430 S. Smallwood St.

15 Filed 8 1930 C. WILKINSON JONES Registrar

Per RRB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1929 to Sept 16, 1930, that I last saw him alive on Sept 16, 1930, and that death occurred, on the date stated above, at 8 50 A. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis
Cholelithiasis

about (duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Conner M. D.

9/16, 1930 (Address) 1101 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Sept 19 1930

UNDERTAKER F. O. Nippert ADDRESS 1850 N. Ballo Ave

Dec.—1-30—M. & T.—250 Bks.

E 60681

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60681

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 S. Montford Ave ST. 1-3 WARD)

2-FULL NAME Frank Kurowski

(a) RESIDENCE NO. 723 S. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) September 5 1865

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	--	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) labor

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr. J Kurowski

(Address) 723 S. Montford Ave

Filed 10 6 1930 19 W. H. WILKINSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 29 1928 to Sept 17 1930

that I last saw h alive on Sept 17 1930 6:30 a.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? M. D.

(Signed) William P Lucas

19 30 (Address) 8 E Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL 9 20 1930

ADDRESS

20 UNDERTAKER Edwin M Weber

ADDRESS 1011 N Chester

Spec.—1-30—M. & T.—250 Bks

E 60682

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60682

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1427 (ST.) Penna. Ave (WARD) 11-20

2-FULL NAME Anne Elizabeth Collins

(a) RESIDENCE NO. 1427 (ST.) Penna. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced (or) HUSBAND of / WIFE of —

DATE OF BIRTH (month, day, and year) 2,

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 80			

OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER John Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Josephine L. Collins

(Address) 1427 Penna. Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 7th, 1930, to Sept 17, 1930, that I last saw h. e alive on Sept 17, 1930, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Pancreatitis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

9/18, 1930 (Address) 1663 W Mold Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Sept 19 19 30

UNDERTAKER Wm J Tuckner Sons

ADDRESS N. Y

Spec.—1-30—M. & T.—250 Bks

E 60683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 60683

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4115 Massachusetts Ave. ST. W. 26-71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolyn May Strong

(a) RESIDENCE No. 4115 Massachusetts Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced (HUSBAND) of (or) WIFE of

DATE OF BIRTH (month, day, and year) Jan. 21, 1923

AGE	Years	Months	Days	If LESS than 1 day.... hrs. or.... min.
	7	7	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER James P. Strong

11 BIRTHPLACE OF FATHER (city or town) Kent Co. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Conner

13 BIRTHPLACE OF MOTHER (city or town) Worcester Co. Md.
(State or country)

14 Informant (Address) Mr. James P. Strong 415 Mass. Ave.

15 Filed SEP 19 1930, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1930

17 I HEREBY CERTIFY, That I attended deceased from JAN 1, 1930, to SEPT. 16, 1930, that I last saw her alive on SEPT 10, 1930, and that death occurred, on the date stated above, at 3.15 P.M. EST.

The CAUSE OF DEATH* was as follows:

OSTEO SARCOMA - RIGHT FEMUR.

(duration) — yrs. 9 mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) C. W. Stoffregen, M. D.

, 19 (Address) 8 East Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem.

DATE OF BURIAL: Sept 19, 30

20 UNDERTAKER: Wm. H. Eichelberger Sons

ADDRESS: North & Pa.

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60684

CERTIFICATE OF DEATH.

X 1- E 60684

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) University Hospital ST. 4-30 (WARD)

2-FULL NAME Charles Hoffman

(a) RESIDENCE NO. Woodlawn (Windsor Mill Road) ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced (or) WIFE of HUSBAND of

DATE OF BIRTH (month, day, and year) June 14 1898

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	3	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto City Balto Md

10 NAME OF FATHER Chas B. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Dora Brummett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Charles B. Hoffman Woodlawn Md

15 Filed SEP 19 1938 H. L. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18th/38

17 I HEREBY CERTIFY, That I attended deceased from Sept 16th, 1938, to Sept 18th, 1938, that I last saw him alive on Sept 18th, 1938, and that death occurred, on the date stated above, at 7:45 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes What test confirmed diagnosis? Autopsy & Lab. work.

(Signed) George Yeaden M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Sept. 22, 19 38

20 UNDERTAKER Wm J. Tichnor & Son

ADDRESS North Pa

pec.—1-30—M. & T.—250 Bks

E 60685

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60685

CERTIFICATE OF DEATH.

45 E 60685

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Gilman Apts ST., 12-50 WARD)

2-FULL NAME Clinton Alvey Stouffer

(a) RESIDENCE NO. Gilman Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced (or) WIFE of HUSBAND of Anna Stouffer

DATE OF BIRTH (month, day, and year) Oct. 8-1846

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
83	73	11	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Wash. D.C.

10 NAME OF FATHER Jonathan Stouffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Mace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lena R. Stouffer (Address) Gilman Apts

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17-30

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1930, to Sept 17, 1930, that I last saw h alive on Sept 17, 1930, and that death occurred, on the date stated above, at 9 P, m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Chas. R. Goldtrough, M. D.

, 19 (Address) 2923 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Sept 19 30

20 UNDERTAKER Wm. J. Tuckner & Sons

ADDRESS N. Y. Pa

Spec.—1-30—M. & T.—250 Bks.

E 60686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 60686

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 St Mathew ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Tapper

(a) RESIDENCE NO. 1218 St Mathew ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Ida Tapper

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day....hrs. or....min.
75			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 670

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

PARENTS

14 Informant J. Lewis (Address) 1439 E Baltimore St

15 Filed 9-19-1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18-30

17 I HEREBY CERTIFY, That I attended deceased from 7/4, 1929, to 9/12, 1930, that I last saw him alive on 9/12, 1930, and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Ch Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) G. G. Thomatteris, M. D.

9/18 1930 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Mt. Carmel

DATE OF BURIAL 9-19 1930

20 UNDERTAKER Jack Lewis, 1439

ADDRESS E Balto St

Dec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60687

101 001

E 60687

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 W Fairmount Ave ST. 18-26 WARD)

2-FULL NAME Henry Wright

(a) RESIDENCE NO. 826 W Fairmount Ave ST., WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1889

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) 643 Fremont Ave

Filed SEP 19 1930 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1930, to Sept 16, 1930, that I last saw h~~e~~ alive on Sept 16, 1930, and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Uter Hemmorrhage

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John M Casey M. D.

. 19 (Address) 743 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 9-19 1930

20 UNDERTAKER Daniel Carter

ADDRESS 916 Park Ave

Spec.—1-30—M. & T.—250 Bks

E 60688

HEALTH DEPARTMENT—CITY OF BALTIMORE

66

CERTIFICATE OF DEATH.

E 60688

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 17-24 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Cooper

(a) RESIDENCE NO. 537 W. Camel ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of or) WIFE of Alice

DATE OF BIRTH (month, day, and year) Oct. 15, 1900

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
29	30	11	1	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) Annapolis

(State or country) Md.

10 NAME OF FATHER Julius

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Sims

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16-30

17 I HEREBY CERTIFY, That I attended deceased from 8-13-30, 19..., to 9-16-30, 19...,

that I last saw h. im alive on 9-16-30, 19...,

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Alcoholism, chr & beats

Psychosis, toxic, alcoholic

(duration) yrs. 1 mos X ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL 9-17 1930

20 UNDERTAKER Daniel Carroll

ADDRESS 916 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60639 E 60639

CERTIFICATE OF DEATH.

65-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 46-32 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ida Walsh

(a) RESIDENCE No. 1923 N. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (a) HUSBAND of (or) WIFE of: Lawrence Walsh

6 DATE OF BIRTH (month, day, and year): May 7, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hagerstown Maryland

PARENTS

10 NAME OF FATHER: Not Obtainable

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn.

12 MAIDEN NAME OF MOTHER: Lily Barber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hagerstown Maryland

14 Informant (Address): Mrs. Lawrence Walsh 1923 N. Lanvale St

15 Filed SEP 19 1930 H. H. JONES, M. D. Registrar

Fee

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to Sept 17, 1930,

that I last saw her alive on Sept 17, 1930,

and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Lymphoid Leukemia

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood & mal x Smears.

(Signed) Robt Heiner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown, Md.

DATE OF BURIAL: 9/20 1930

20 UNDERTAKER: Henry L. Myers

ADDRESS: Thos H. Calvert

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60690

CERTIFICATE OF DEATH

90 ✓

E 60690

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 104 S Wolfe ST. 2-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian Baesch

(a) RESIDENCE NO. 104 S Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Baesch

6 DATE OF BIRTH (month, day, and year) Dec 25 1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	9	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Victor Bot Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Randolph Baesch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederica Hoemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederica Baesch

(Address) 5 E. Montgomery St.

15 Filed [illegible] 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

6 (duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) H C Gladden, M. D. Coroner

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Sept 20 1930

20 UNDERTAKER F. A. Williamson

ADDRESS 903 Hanover

Dec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60691

CERTIFICATE OF DEATH

46 60691

REGISTERED NO. 8-45

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1685 Darley Av. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ben. F. Daniels

(a) RESIDENCE NO. 1685 Darley Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. F. Daniels

DATE OF BIRTH (month, day, and year) Feb. 5-1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	7	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Ephriam Dare.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Martha Edwards.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Joseph F. Daniels

(Address) 1685 Darley

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17-1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to Sept 17, 1930

that I last saw h[illegible] alive on Sept 17, 1930

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension, Cerebral Hemorrhage

Carcinoma Uteris (2 mo)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic & Symptoms.

(Signed) Thos. F. Ferris, M. D.

9-18. 1930 (Address) 2878 Hartford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Sept 20 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Pleasant

1936 [illegible] JONES, M. D.

pec.—1-30—M. & T.—250 Bks.

60692

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 31 VE 60692

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Neis

(a) RESIDENCE NO. 2216 E Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Frederick C. Neis

DATE OF BIRTH (month, day, and year) June 29-1876

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	2	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Wm Heiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fredk. C. Nies

(Address) 2216 E Madison

15 Filed ..... 19 ..... at ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930, to Sept. 17, 1930, that I last saw h[e] alive on Sept. 17, 1930, and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. mos 7 ds (?)

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Sept 20 1930

20 UNDERTAKER John Ulrich

ADDRESS 2018 Eutaw

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60693

CERTIFICATE OF DEATH.

100-001

E 60693

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 26-37 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brandt

(a) RESIDENCE NO. 504 S. Haven ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1888 ?

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) do do

(c) Name of employer Geo. Gunter Brewery

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 19 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16-30

17 I HEREBY CERTIFY, That I attended deceased from 9-15-30, 19..., to 9-16-30, 19..., that I last saw him alive on 9-16-30, 19..., and that death occurred, on the date stated above, at 7:55 A. m.

The CAUSE OF DEATH* was as follows

Alcoholism, Chr. Acute

Psychosis, toxic, alcoholic

Autopsy. (duration) ... yrs. ... mos ... da.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ... yrs. ... mos. 2 da.

18 Where was disease contracted if not at place of death? Autopsy

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jas. Ghrist Jr. M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL Sept 17th 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 4000 N. Wolfe St

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

E 60694

E 60694

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3621 Spaulding Ave ST., 15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna O. Ruck

(a) RESIDENCE NO. 3621 Spaulding Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Lewis E. Ruck

7 DATE OF BIRTH (month, day, and year) Feb. 6 1888

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Charles Schlaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Magdelen Hauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Lewis E. Ruck

(Address) 3621 Spaulding ave

Filed Sept 19 1930 J. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18/30

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Sept 18, 1930,

that I last saw h.. alive on Sept 17, 1930,

and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) H. Lee Tilson, M. D.

19 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Sept. 20 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St

pec.—1-30—M. & T.—250 Bks.

E 60695

100-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 13-52 WARD)

2-FULL NAME Stanley Reilly

(a) RESIDENCE NO. 4109 Falls Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Julia A. Reilly

7 DATE OF BIRTH (month, day, and year) Nov 13 1877

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	10	4	

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work machinist

(b) General nature of Industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James T. Reilly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed 1 8 1930 19 E. Kay JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-17-30

17 I HEREBY CERTIFY, That I attended deceased from 9-3, 1930, to 9-17, 1930, that I last saw h[illegible] alive on 9-17, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Obesity - Pernicious anemia

Sepsis. (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? question

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hugh J. Leucht, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Govans — DATE OF BURIAL July 20 1930.

20 UNDERTAKER Horace H. Burgee — ADDRESS 1631 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

E 60696

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60696

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2033 E Oliver ST. 5-17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philipine Sommerman

(a) RESIDENCE NO. 2033 E Oliver ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Sommerman Sr

6 DATE OF BIRTH (month, day, and year) July 15, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo. Baeckmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) 2033 E Oliver St

15 Filed 9-19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-14 1930 to 9-18 1930

that I last saw her alive on 9-18 1930

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Findings

(Signed) David Miller, M. D.

9/19 1930 (Address) 1502 E Oliver St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 9/22 1930

ADDRESS

20 UNDERTAKER Albert L Hilleb 1606 N Chester St

pec.—1-30—M. & T.—250 Bks.

E 60697

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60697

CERTIFICATE OF DEATH.

REGISTERED NO. 31 VE 60697

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1280 Riverside ave ST., 24th (WARD)

2-FULL NAME Margaret A Schwartz

(a) RESIDENCE NO. 1280 Riverside ave ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced (a) HUSBAND of or) WIFE of Henry A. Schwartz

7 DATE OF BIRTH (month, day, and year) Oct 16 1907

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Elsner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ella. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Henry A. Schwartz 1280 Riverside ave

15 Filed ..., 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1930, to Sept 18, 1930; that I last saw h[illegible] alive on Sept 18, 1930; and that death occurred, on the date stated above, at 11.5 5 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs 8 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schwartz M. D.

, 19 (Address) 1337 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co

DATE OF BURIAL 9-22 1930

ADDRESS

20 UNDERTAKER E & V S Harlr 115 E Mead St.

[illegible] JONES, M. D.

pec.—1-30—M. & T.—250 Bks.

E 60698 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60698

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1153 Riverside Ave ST., 7th WARD)

2-FULL NAME William Edw. Reitz

(a) RESIDENCE NO. 1153 Riverside Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) January 13 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	5	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edw. Wm. Reitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Marie Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Edw Wm. Reitz 1153 Riverside Ave

15 Filed SEP 19 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Sept 18, 1930, that I last saw him alive on Sept 18-th, 1930, and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos 22 ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G. H. Burton M. D.

19 , 1930 (Address) 306 E. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 9-20 1930

20 UNDERTAKER E. B. Hall 115 E West St.

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60699 — 74 — 601 E 60699

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 725 Pierce ST. 17-26 (WARD)

2-FULL NAME Millie Payne

(a) RESIDENCE NO. 725 Pierce ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of Thomas Payne

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thomas Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Etta White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Ethel Wyatt
(Address) 1912 Ashland Ave.

15 Filed Sept 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17/30.

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Sept 17, 1930, that I last saw h[illegible] alive on Sept 16, 1930, and that death occurred, on the date stated above, at 10 20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ... yrs. ... mos 20 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) S. W. McCard M. D.

9/19, 1930 (Address) 2029 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwater Co. Va

DATE OF BURIAL Sept 19, 30

20 UNDERTAKER Wm. H. Elliott

ADDRESS 1725 Ashland Ave

1-30—M. & T.—100 B—50L

Thomas L Hynes ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

60700 E 60700

CERTIFICATE OF DEATH

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4002 Massachusetts ST. 10-21 WARD)

2-FULL NAME Thos L Haynes

(a) RESIDENCE NO 4002 Massachusetts Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Adelaide J Hynes

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mo. Collector
(b) General nature of industry, business, or establishment in which employed (or employer) City
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Patrick J Haynes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Honora Twohy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Honor Dunlea

(Address) 210 Augusta Ave

15 Filed SEP 19 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Convulsions - Uremia
Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. H. Bromley, M. D.
Coroner

9/8 1930 (Address) Broadway Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL Sept 20 1930

20 UNDERTAKER Frye & Tuohy ADDRESS Fulton & Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60701 46 E 60701

REGISTERED NO. 1930-33

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 26 East Kennet WARD 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Ann Lycett

(a) RESIDENCE NO. 26 East Kennett WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm H. Lycett

DATE OF BIRTH (month, day, and year): Jan. 18, 1853

AGE: Years 77 Months 7 Days 29 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: Henry Vogelgesang

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Mary Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

Informant: Margaret Young Sister

(Address) 1541 Hanover St.

Filed SEP 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 16, 1930.

17 I HEREBY CERTIFY, That I attended deceased (from July 15 1930 to Sept. 16 1930.

that I last saw her alive on Sept 16 1930 at 8.50 P m.

and that death occurred, on the date stated above, at Eastern Standard Time

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri, metastases to Pelvic glands (duration) mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris M. D.

(Address) 107 East west St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Sept. 20 1930

20 UNDERTAKER: Margaret E. Flynn

ADDRESS: 14 & 16 Eight St.

Cor.—10-10-29—A Co.—100 Bks.

60702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 60702

REGISTERED NO. 9435

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. B. & O. R. R. Yards Locust Point St., Ward)

2-FULL NAME James T. Fitzgerald.

(a) RESIDENCE NO. 1628 E. Fort Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 10 mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anne Fitzgerald.

6 DATE OF BIRTH (month, day, and year) November 15, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Car repair helper.
(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Jefferson Fitzgerald.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Anne Fitzgerald. (wife)
(Address) 1628 E. Fort Ave.

15 Filed ..... 19..... [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 17, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial insufficiency.
Acute dilatation of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Ehrhardt, M. D.

9/17, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross R. C. Cem

DATE OF BURIAL Sept 20 1930

20 UNDERTAKER Margaret E. Flynn 1417 Light St

ADDRESS

pec.—1-30—M. & T.—250 Bks

E 60703

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60703

CERTIFICATE OF DEATH.

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. WARD)

2-FULL NAME Howard Bryant

(a) RESIDENCE NO. 332 Chancery Road, Guilford WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mrs Lillian E Bryant

7 DATE OF BIRTH (month, day, and year) July 21 1861

AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
69		1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 042

(b) General nature of industry, business, or establishment in which employed (or employer) Pres. of City Council

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canton, Md.

PARENTS

10 NAME OF FATHER J. W. Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Cork

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Lillian Bryant

(Address) 3 or Johnson Rd.

Filed SEP 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Sept 18, 1930, that I last saw h[illegible] alive on Sept 18, 1930, and that death occurred, on the date stated above, at 5:20 p m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? History

(Signed) Francis W. Gluck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Sept 20, 30

20 UNDERTAKER Arthur O Mitchell & Son ADDRESS 1911 Eutaw Pl

pec.—1-30—M. & T.—250 Bks

E 60704 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

31 E 60704

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals ST., 13-59 WARD)

CITY OF BALTIMORE: (NO.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Telow

(a) RESIDENCE NO. 1340 N. Carrollton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced
HUSBAND of Sarah Telow
or) WIFE of

7 DATE OF BIRTH (month, day, and year) October 1, 1870

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Latvia

PARENTS

10 NAME OF FATHER Yaluke Telow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Latvia

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Latvia

14 Informant Hospital Records
(Address) Baltimore City Hospitals

15 Filed 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18/30

17 I HEREBY CERTIFY, That I attended deceased from 7/28/30, 19 , to 9/18/30, 19 ,
that I last saw h alive on 9/18/30, 19 ,
and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:
Arteriosclerotic Cardiovascular
Renal Disease
(duration) unknown yrs. mos ds.
CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) David Feuer, M. D.
9/18/1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hering Rem

DATE OF BURIAL Sept 19 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Baltimore St

Spec.—1-30—M. & T.—250 Bks.

E 60705 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60705

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 N. Pulaski ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Tevis

(a) RESIDENCE NO. 1606 N Pulaski ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Rachael Tevis

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Joseph Tevis
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18-30

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 21 to Sept. 18, 19 30,

that I last saw him alive on Sept. 18, 19 30,

and that death occurred, on the date stated above, at 11 P ES.T. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M.S. Gelman M. D.

9/19 1930 (Address) 1575 N Bentalou st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rosedale

DATE OF BURIAL Sept 19 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

60706 E 60706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH,

34

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME Calvin Watson

(a) RESIDENCE No. 1605 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of unknown.

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Calvin Watson ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lida ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant (Address) Baltimore City Hospitals

15 Filed 9 19 30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14-30

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1929, to 9-14, 1930,

that I last saw him alive on 9-14-, 1930,

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lumbar and sacral spine.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Clinical signs & X-ray

(Signed) Fred M. Auckwall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

JOHNS HOPKINS HOSP. SEP 1 - 1930 19

20 UNDERTAKER — ADDRESS

Commissioner Health Sr. SEP 1 - 1930

CLAWSON JONES

SEP 1 1930

Spec.—1-30—M. & T.—250 Bks

60707 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 60707

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals 4-6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME William Moore

(a) RESIDENCE NO. 123 South ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Moore

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lawrence

(State or country) S. C.

PARENTS

10 NAME OF FATHER Ziek Moore

11 BIRTHPLACE OF FATHER (city or town) Lawrence

(State or country) S. C.

12 MAIDEN NAME OF MOTHER Charlotte Mauce

13 BIRTHPLACE OF MOTHER (city or town) Lawrence

(State or country) S. C.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed SEP 19 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13-30

17 I HEREBY CERTIFY, That I attended deceased from 7-7-30, 19..., to 9-13-30, 19..., that I last saw him alive on 9-13-30, 19..., and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma with metastases to liver and portal obstruction

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Gerald Jr, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health

SEP 19 1930

pec.—1-30—M. & T.—250 Bks.

6409

60708

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60708

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6111 Ridgeview St., 27-42 WARD)

2-FULL NAME Frederick R Horsley

(a) RESIDENCE No. 6111 Ridgeview ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) ~~WIFE~~ of Isabel Horsley

7 DATE OF BIRTH (month, day, and year) May 6 1864

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	4	12	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Stationery

(c) Name of employer Richardson Co

10 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Horsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Anna Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Isabel Horsky

(Address) 6111 Ridgeview

15 Filed 9-1930 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18-1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to Sept 18, 1930, that I last saw h~~im~~ alive on Sept 18, 1930, and that death occurred, on the date stated above, at 3 P m. Standard time

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

Acute Dilatation Heart

Arterio-sclerosis (duration) yrs. mos ds.

CONTRIBUTORY mytral regurgitation Heart (Secondary) Nephritis Chronic (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G Webster M. D.

Sept 19 1930 (Address) 6404 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Sept 20 1930

20 UNDERTAKER Wm Cook

ADDRESS 12 S Paca

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60709

CERTIFICATE OF DEATH.

14 201 60709

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves ST., H-7 WARD)

2-FULL NAME Mrs Anna Lawlor

(a) RESIDENCE NO. 8 E Mulberry ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Lawlor

6 DATE OF BIRTH (month, day, and year) Aug. 17 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Organist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Mc Glinchey

11 BIRTHPLACE OF FATHER (city or town) Brooklyn (State or country) New York

12 MAIDEN NAME OF MOTHER Allfridge

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Elmer Lawlor

(Address) 240 E Lanvale St

15 C. HARRISON JONES, M. D.

Registrar

SEP 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-17, 1930, to 9-19, 1930, that I last saw her alive on 9-19, 1930, and that death occurred, on the date stated above, at 6 40 a m. Standard Time

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hjalmar S Anderson, M. D.

19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 9/22 1930

20 UNDERTAKER Henry U. Myers & Son

ADDRESS 805 N. Calvert

Cor.—1-12-23—M&T—100 Bks.

E 60710

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60710

CERTIFICATE OF DEATH.

REGISTERED NO. 17 359

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Union Memorial Hosp. ST., WARD
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Meyer Mason

(a) RESIDENCE NO. 4005 Keswick Rd ST., WARD Resident.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? 44 yrs. 5 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of J. Dudley Mason

6 DATE OF BIRTH (month, day, and year) April 16 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Adolph C. Meyer

11 BIRTHPLACE OF FATHER (city or town) Bremen
(State or country) Germany

12 MAIDEN NAME OF MOTHER Florence Stellmann

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Mr. J. Dudley Mason (Husband)
(Address) 4005 Keswick Road

15 1930 Registered by HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Fall Accidental

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) H. Hamilton Jones, M. D.
(Coroner.)

9/19, 1930 (Address) 2624 Boulevard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 0 yrs., 0 mos. 15 Min. In the State 44 yrs., 5 mos., 3 ds.

(Where was disease contracted, if not at place of death?)
4005 Keswick Road.

Former or usual residence 4005 Keswick Rd

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL Sept 1930

20 UNDERTAKER Leonard M. Conrad & Bulla ADDRESS

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60711

109-002

E 60711

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. St.) (WARD) Stockman

2-FULL NAME Anne Singleton Stockman

(a) RESIDENCE NO. Alhambra Apts, Lake Drive WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of: William Stockman

6 DATE OF BIRTH (month, day, and year): June 26, 1891

7 AGE: Years 39; Months 2; Days 24; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Buyer 086

(b) General nature of industry, business, or establishment in which employed (or employer): Retail-corset house

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hartford, Conn.

PARENTS

10 NAME OF FATHER: Michael G. Singleton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Soldier England

12 MAIDEN NAME OF MOTHER: Julia Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Covington Conn.

14 Informant (Address): Alhambra Apts

15 Filed 9-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/19/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Sept 19, 1930, that I last saw her alive on Sept 19, 1930, and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows: D.S.

Agranulocytic angina

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes, blood count

What test confirmed diagnosis?

(Signed) Francis W. Black, M. D.

9/19 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkland Conn

DATE OF BURIAL: 9/19 1930

20 UNDERTAKER: L. A. Lakey Sons

ADDRESS: 911 Light

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60712 E 60712

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5005 Benton Heights Ave. St.) (27-41 Ward)

2-FULL NAME John P. Hendler

(a) RESIDENCE NO. 5002 Irdmore Way Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida V. Hendler

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	44	1	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cable splicer
(b) General nature of industry, business, or establishment in which employed (or employer) Police Dept. 1886
(c) Name of employer Balto

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs. Ida V. Hendler
(Address) 5002 Irdmore Way

15 Filed ..... 19.... Registrar

20 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Chr Myocarditis- Angina Pectoris

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..... M. D.

9/17/30 (Address) 1108 E orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Sept. 20 1930

20 UNDERTAKER Wm. Wickner & Son — ADDRESS North Pa

Spec.—1-30—M. & T.—250 Bks.

240601 E 60713

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 ✓ E 60713

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) 76-37 (WARD)

2-FULL NAME Charles Gibson

(a) RESIDENCE NO. 3711 Gough ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Infant-

6a If married, widowed, or divorced (HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) Aug 6-1930

8 AGE — Years: ~~Months~~ ward 9 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ditto

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Md

11 NAME OF FATHER Albert Gibson

12 BIRTHPLACE OF FATHER (city or town) (State or country) Md

13 MAIDEN NAME OF MOTHER Lillian Fox

14 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

15 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed ..... 19 .....

SEP 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-19-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept-11, 1930, to Sept-19, 1930, that I last saw him alive on Sept-19, 1930, and that death occurred, on the date stated above, at 3 52 p. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) ..... yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Mary Adams, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: Sept 22, 30

20 UNDERTAKER: George W. Zinkler — ADDRESS: 1737 E. Eager St.

Spec.—1-30—M. & T.—250 Bks

1714

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 Schlinger E 60714

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3912 Tait ave ST., [redacted] WARD)

2-FULL NAME Amelia Engel

(a) RESIDENCE NO. 3912 Tait ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Clements E. Engel.

6 DATE OF BIRTH (month, day, and year): Jan. 18 1858

7 AGE: Years 72 Months 8 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ernest Wicke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Clements E. Engel Husband

(Address): 3912 Tait ave

15 Filed [redacted] 19 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 18th 30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19 1928 to Sep. 18 1930, that I last saw h[illegible] alive on Sep. 18th 1930, and that death occurred, on the date stated above, at 10.00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Degeneration Myocarditis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis J. Schmidt M.D.

19 (Address) 6016 Eastern Ave - Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery

DATE OF BURIAL: Sept 22nd 1930

20 UNDERTAKER: Lilly & Zeiler Inc.

ADDRESS: 403 S. Wolfe St

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60715

CERTIFICATE OF DEATH

51 E 60715

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 1124 (STREET) Stockton (WARD) 16-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sadie Brooks

(a) RESIDENCE NO. (Usual place of abode) 1124 Stockton WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of 0

7 DATE OF BIRTH (month, day, and year) Date not known

8 AGE 42 Years | Months 0 | Days 0 | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Corporation

(c) Name of employer St Joseph

10 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Samuel Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Catherine Hicks

(Address) 1328 N. Calhoun St

15 Filed ..... 1930 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Sept 17, 1930, that I last saw h alive on Sept 16, 1930, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus

Personal knowledge (duration) mos. 30 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of 0

Was there an autopsy? No What test confirm diagnosis? Postmortem

(Signed) John C Stewart M. D.

19 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn | DATE OF BURIAL Sept 20 30

20 UNDERTAKER Virginia A. Brooks. | ADDRESS 1463 N. Carey St

1-30—M. & T.—100 B—50L

E 60716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 60716

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital ST., 27-44 WARD)

2-FULL NAME Katherine Price

(a) RESIDENCE NO 4102 Prior ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Price

6 DATE OF BIRTH (month, day, and year) July 18. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Rabeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Price

(Address) 4102 Prior ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
acc fall down cellar steps
Fracture of R. Femur

(duration) Yrs. mos. 6 days

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 4102 Prior ave

Did an operation precede death? — Date of —

Was there an autopsy? Sept 19 1930

What test confirmed diagnosis? Clinical Findings

(Signed) A. G. Wade Coroner, M. D.

19 (Address) 4336 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 23 1930

20 UNDERTAKER August Paseke — ADDRESS 2406 Ashland ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60717 112 E 60717

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 208 McCulloh St. 14-20 Ward)

2-FULL NAME John Nash

(a) RESIDENCE NO. 208 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Autum

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER Autum

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Autum

12 MAIDEN NAME OF MOTHER Autum

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Autum

14 Informant Geo. Gibson
(Address) 1458 McCulloh St

15 Filed ....., 19 .... 10:57 A.M. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mc Endocarditis
Cross of Heart

(duration) ..... yrs. ..... mos. — ds.

CONTRIBUTORY (Secondary) Ac Cardiac Dilation

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical History

(Signed) H C Glades, M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Sept 20 30
20 UNDERTAKER Arnold J Stanley	ADDRESS 712 Bdle

Spec.—1-30—M. & T.—250 Bks

E 60718

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

38 E 60718

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 27-48 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Anderson

(a) RESIDENCE NO. 1603 E. Walker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Rowena

7 DATE OF BIRTH (month, day, and year) Feb. 12, 1880

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sommer Fertilizing Co.

9 BIRTHPLACE (city or town) (State or country) Augusta Ga.

10 NAME OF FATHER Jubius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Hepsy Emory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

PARENTS

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16-30

17 I HEREBY CERTIFY, That I attended deceased from 7-7-30, 19..., to 9-16-30, 19...

that I last saw him alive on 9-16-30, 19...

and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency

More than (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myocard. fis. Chronic

(duration) yrs. 0 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray. Wassermann.

(Signed) Paul Padgett M. D.

9-17, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem.

DATE OF BURIAL 9-20 1930

20 UNDERTAKER Byrow & Wright 128 McElderry

ADDRESS

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60719

E 60719

CERTIFICATE OF DEATH

194

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 32 S Caroline St. 3-4 WARD)

2—FULL NAME James Frazer

(a) RESIDENCE NO. 32 S Caroline St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. Life mos. da. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Sophia Frazer

DATE OF BIRTH (month, day, and year) Sept 15, 1866

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64		2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto md.

10 NAME OF FATHER John Frazer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

Informant Chas Frazer

(Address) 32 S Caroline St

Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9.17.30

17 I HEREBY CERTIFY, That I attended deceased (from June, 1930, to Sept 17, 1930, that I last saw him alive on Sept 16, 1930 and that death occurred, on the date stated above, at 11 P. m. Standard Time.

The CAUSE OF DEATH* was as follows:

Myocarditis.
Heat Exhaustion

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
Heat Exhaustion
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard Harris, M. D.

Sept 19, 1930 (Address) 38 S Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Gardens

DATE OF BURIAL Sept 21 1930

20 UNDERTAKER Theodore L White

ADDRESS 1133 Hughes St

1-30—M. & T.—100 B—50L

E 60720

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60720

CERTIFICATE OF DEATH

REGISTERED NO. 21-24 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1343 Ward ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sam Williams

(a) RESIDENCE NO. 1343 Ward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Rag Picker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant Phoebe Robinson

(Address) 1343 Ward

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia. (Right Lung)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/18 1930 (Address) Forrest Md Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Sept 21, 1930

20 UNDERTAKER: Mrs Katie R. Williams

ADDRESS 322 N Arrowdale St

Spec.—1-30—M. & T.—250 Bks

E 60721 E 60721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH Union Memorial Hospt. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 12-49 ST. WARD)

2-FULL NAME Myer Cohen

(a) RESIDENCE NO. 2101 Connecticut ave ST., WARD Washington DC
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Helen Cohen

6 DATE OF BIRTH (month, day, and year) July 4 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or, min.
	64	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Moses Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Loeb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant self
(Address)

15 Filed SEP 20 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 14th, 1930, to Sept 20th, 1930, that I last saw h[illegible] alive on Sept 20th, 1930, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cancer stomach

(duration) 7 mos. yrs. mos. ds.

CONTRIBUTORY (Secondary) Pa[illegible]enter shock

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 18th 1930

Was there an autopsy? no

What test confirmed diagnosis? Question

(Signed) Francis W Clark, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. Lot

DATE OF BURIAL Sept 20 1930

20 UNDERTAKER Morris H. Hyson

ADDRESS 1300 [illegible]

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60722

CERTIFICATE OF DEATH.

129 E 60722

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals 4-25

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Lennox

(a) RESIDENCE NO. 602 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Robert Lennox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Teresa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of
(Address) Balto. City Hosp.

Filed ..... 20 1930 ..... C. HUNTER JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16-30

17 I HEREBY CERTIFY, That I attended deceased from 4-16-27, 19 ..... to 9-16-30, 19 .....

that I last saw him alive on 9-16-30, 19 .....

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, with oedema

(duration) 3½ yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic infection

(duration) 3½ yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

9-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 9/20, 1930

20 UNDERTAKER John J. Fahey Sons

ADDRESS 1318 Eutaw St

Spec.—1-30—M. & T.—250 Bks

60723

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 60723

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 11-7 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Fernen

(a) RESIDENCE NO. 611 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of or) WIFE of Emilie

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Bernard Fernen

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Meehan

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 9 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-15-30

17 I HEREBY CERTIFY, That I attended deceased from 6-23-30, 19, to 9-15-30, 19, that I last saw him alive on 9-15-30, 19, and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia left with Hemorrhage into R cerebrum

(duration) yrs. 3 ½ mos da.

CONTRIBUTORY (Secondary) Hypertention

unknown (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. E. Arnold Jr., M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 9/20, 19 30

20 UNDERTAKER John J. Fahey Son

ADDRESS 1318 Eutaw St

1-30—M. & T.—100 B—50L

E 60724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 161-001

E 60724

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ignatius Umerly

(a) RESIDENCE NO Essex, Md. Deep Creek Ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 12/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex, Md.

PARENTS

10 NAME OF FATHER Ignatius Umerly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Scorern

13 BIRTHPLACE OF MOTHER (city or town) Penna. (State or country)

14 Informant Ignatius Umerly

(Address) Essex Md.

15 Filed 2 0 1930 (192) [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 19/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity-6 mons gestation
(One of twins)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.

9/20/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart of Mary

DATE OF BURIAL 9/20/1930

20 UNDERTAKER John S. Connolly

ADDRESS Essex

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60725

CERTIFICATE OF DEATH.

31 V E 60725

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Aisquith St. 10-14 WARD)

2-FULL NAME Saddie Jackson

(a) RESIDENCE NO. 825 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D.C.

12 MAIDEN NAME OF MOTHER Saddie Schoffield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Saddie Jackson (mother) 825 Aisquith St

15 Filed [illegible] Registrar

P 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1930, to Sept 18, 1930, that I last saw h[illegible] alive on Sept 12, 1930, and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) [redacted]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. L. Yaffey, M. D.

9/18, 1930 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Cemetery

DATE OF BURIAL Sept 20, 1930

20 UNDERTAKER Miss Ida Saunders

ADDRESS 1908 E Madison St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60726 15 E 60726

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 851 W. 35th St (ST.) 13-52 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Ellen McCauley

(a) RESIDENCE NO. 851 W. 35th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 10 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 16- 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50.	10.	4.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. H. McCauley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Martha J. Mister

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm. H. McCauley

(Address) 851 W. 35th St

15 Filed 1 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1930, to Sept 20, 1930, that I last saw her alive on Sept 20, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: General Sepsis (Septicemia)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Infection of Leg. Right.

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) James L. Akehurst, M. D.

(Address) 1012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's, Stamford Conn. DATE OF BURIAL Sept 23 1930

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Fallsway

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60727 90 E 60727

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) John Hopkins Hospital St., 15-58 Ward

2-FULL NAME Morris Barondess

(a) RESIDENCE NO. 2530 Boarman Ave., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	White married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rose Barondess

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Rose Barondess (Wife)
(Address) 2530 Boarman Ave.,

Filed 9 21 1930 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9- 19- 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Arteriosclerotic heart Disease
Trisuspid Insufficiency
(duration) yrs. mos. ds.
"History of Rheumatism"
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes at Hopkins
What test confirmed diagnosis?
(Signed) J. H. Bell, M. D.
9. 20/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herrong Run — DATE OF BURIAL 9-21-1930

20 UNDERTAKER Jack Lewis, 1439 Bank st — ADDRESS

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60728 — 90 E 60728

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 242 S. Eden St., 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Lena Kahn

(a) Residence No..... 242 S. Eden St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Harris Kahn

6-DATE OF BIRTH (month, day and year)

7-AGE. 76 yrs. — mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: Private

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Solomon Mayer

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14- (Informant)..... S. Kahn (Son)

(Address)..... 242 S. Eden St.

15- Filed SEP 21 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 20/1930

17- I HEREBY CERTIFY, That I attended deceased from June 20 1925 to Sept 20 1930.

That I last saw h[illegible] alive on Sept 20 1930.

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 10 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Insufficiency

(Duration) 10 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John J. Steck M. D.

Sept 20 1930 (Address) 936 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Sinai Cem. DATE OF BURIAL, 9-4- 1930

20-UNDERTAKER, Rod Levin ADDRESS 1439 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

E 60729 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60729

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Levine

(a) RESIDENCE NO. 1922 E Fayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Selma Levine

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Israel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frah-

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Selma Levine

(Address) 1922 E Fayette St

15 Filed 2-1 1930 By C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-18 1930 to 9-20 1930

that I last saw him alive on 9-20 1930

and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach -

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Post operative Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? Yes Date of 9-22-30

Was there an autopsy? Yes No

What test confirmed diagnosis? X-Ray Exam

(Signed) H. James S Andrews M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine North Point Shrine Memorial Hill DATE OF BURIAL 9-21- 1930

20 UNDERTAKER Jacob Lewis ADDRESS 1739 Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

E 60730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60730

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2514 Maryland St., 12-51 Ward)

2-FULL NAME Mattie F. Reese

(a) RESIDENCE NO. Elder: State of Washington (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jotty Reese

6 DATE OF BIRTH (month, day, and year): Sept 10 1880

7 AGE: Years 50 | Months 0 | Days 10 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Ga
(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Unknown

14 Informant: W. M. Reese
(Address): Elder Grays Harbor State

Filed SEP 21 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jaboulac
Disease of
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dan'l Norman, M. D.

9/20 1930 (Address) 1032 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friends (Fallston Md) Cemetery

DATE OF BURIAL: 9/22/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

Dr Fisher 1823 N Wash St

E 60731

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60731

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 N Chester ST. 8-17 WARD)

2-FULL NAME James L Burke

(a) RESIDENCE NO. 1832 N Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Mary F Burke

6 DATE OF BIRTH (month, day, and year): Nov 17. 1851

7 AGE — Years: 78 Months: 10 Days: 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): John F Burke 1832 N Chester St

15 Filed ..... 19 ..... THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 20. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to Sept 20, 1930.

that I last saw h alive on Sept 19, 1930,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Arteri Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob Fisher M. D.

9/20 1930 (Address) 1823 N. Wash. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 9/22/1930

20 UNDERTAKER: J M Cook

ADDRESS: 1217 St Paul St

1-30—M. & T.—100 B—50L

E 60732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 60732

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital ST. 24-34 WARD)

2-FULL NAME James A Keefe

(a) RESIDENCE NO 220 Barney ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced (write the word)~~
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Keefe

6 DATE OF BIRTH (month, day, and year) Sept 15th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	0	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fish Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Susanna Trimteo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Margaret K. Keefe

(Address) 220 E. Barney St

15 Filed 2 1 1930 492 C. HAMPSON JONES, M. D. Registrar Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(Duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 220 Barney

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. G. Gladding, M. D. Coroner

, 19 (Address) 173 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

20 UNDERTAKER Wm Cook

DATE OF BURIAL 9/23 1930

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

E 60733

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60733

CERTIFICATE OF DEATH.

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3117 Keswick Road ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Armstrong

(a) RESIDENCE NO. 3117 Keswick Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 4-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pennsylvania Railroad

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Frank T. Uebel

(Address) 3117 Keswick Road

15 Filed 2-1-1930, 19 C. H. WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 19, 1930, that I last saw h.. alive on Sept 19, 1930, and that death occurred, on the date stated above, at 9-33 P. m.

The CAUSE OF DEATH* was as follows: Paralysis Agitans

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm. Thos. Lee M. D.

Sept. 22, 1930 (Address) 600 N. Arch St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Feb. 22 1930

UNDERTAKER Horace F. Burgee

ADDRESS 363 Falls Road

Cor.—10-10-29—A Co.—100 Bks.

E 60734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-002

E 60734

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) John Hopkins Hosp (Ward) 21-29

2-FULL NAME Edna C Arnold

(a) RESIDENCE NO. 1016 W Cross St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Dec 5th 1929

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harry B Arnold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine Tarbert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md.

14 Informant Mr Harry B Arnold
(Address) 1016 W Cross St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Ulcerative Colivis Dysentery

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 608 E. North Ave 9/21/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tudor Park Cem.	9/22/1930
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins St.

Important.—See instructions on back of certificate.

Spec. 2-29-28—L. F. S.—500 Bks.

Staudenmeier

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60735

CERTIFICATE OF DEATH

129 E 60735

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Staudenmeier

(a) RESIDENCE NO. 2538 E. Biddle ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Staudenmeier

DATE OF BIRTH (month, day, and year) Apr 16 - 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	5	4	

OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Brass Foundery

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Caroline Staudenmeier

(Address) 2530 E Biddle St

Filed 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/30

17 I HEREBY CERTIFY, That I attended deceased from 8/8, 1930, to 9/20, 1930,

that I last saw him alive on 9/20, 1930

and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows:

Chronic Prostatetis

Chronic Nephritis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/13/30

Was there an autopsy? No

What test confirmed diagnosis? Operative

(Signed) H. A. Kahn, M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Westerns Cem

DATE OF BURIAL Sept 23 1930

20 UNDERTAKER John Ulrich

ADDRESS 808 Greene

Spec.—1-30—M. & T.—250 Bks.

E 60736 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60736

CERTIFICATE OF DEATH.

REGISTERED NO. 194

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 N. Monroe ST., 710 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Lind

(a) RESIDENCE NO. 2413 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of: John Lind

6 DATE OF BIRTH (month, day, and year): Sept 29 1847

7 AGE: Years 85 | Months 11 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Christmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Margaret Breitenbach

(Address) 2413 N. Monroe

Filed 2 1 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19-1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to Sept-19-1930, that I last saw h. alive on Sept-18, 1930, and that death occurred, on the date stated above, at 1 45 P. m.

The CAUSE OF DEATH* was as follows:

Senility + Heart Depression

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary): Ex Lawton

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Mark E Brown M. D.

, 19 (Address) 125 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Sept 22 1930

20 UNDERTAKER: John Ulrich

ADDRESS: 900 Eutaw

Spec.—1-30—M. & T.—250 Bks

E 60737 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-42 60737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 2208 Corbin road W. Hamilton ST. 27-43 WARD

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine E. Wills

(a) RESIDENCE NO. 2208 Corbin road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced (HUSBAND of / or) WIFE of late Chas. H. Wills

6 DATE OF BIRTH (month, day, and year) Apl 20/52

7 AGE — Years: 78 | Months: 5 | Days: — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS
10 NAME OF FATHER Henry Boshammer
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER Elizabeth
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Anna Wigner
(Address) 2216 Corbin road

15 Filed 1930 19 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 19 30, to Sept 20, 19 30, that I last saw h[illegible] alive on Sept 19, 19 30, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:
Cerebral arteriosclerosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Senility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) 5106 Oxford av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 9/20, 19 30

20 UNDERTAKER: Philip Sterrig — ADDRESS 2046 Orleans St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60738

CERTIFICATE OF DEATH

E 60738

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hosp Ward 1-3) St., ____

2-FULL NAME Teofila Palachowska

(a) RESIDENCE NO. 206 Gough St St., Ward Syracuse N.Y.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
F	Wh	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph Palachowska

6 DATE OF BIRTH (month, day, and year) Apr 14 - 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bean Picker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country) Poland

PARENTS

10 NAME OF FATHER ____

11 BIRTHPLACE OF FATHER (city or town) Stanislawzeszowska Poland
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Kolinowski

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Poland

14 Informant Adolph Palachowska
(Address) 206 Gough St

15 Filed ____ 19__ ____ Registrar

2-1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fell from track in which she was working

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? near Belair Md

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. F. Fraser M. D.

9/20 1930 (Address) 329 311 E Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	9 23 1930
20 UNDERTAKER	ADDRESS
J. Wm Wroten	401 N Charles

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 60739 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60739

CERTIFICATE OF DEATH. 96

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3917 Northern Parkway ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Knapp

(a) RESIDENCE NO. 3917 Northern Parkway ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Anna Knapp

6b DATE OF BIRTH (month, day, and year): March 22 1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	22	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman retired 7 Years

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Koch Importing Co.

8 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Leonard Knapp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Josephine Neu

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna Knapp (Address) 3917 Northern Parkway

15 Filed 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 20 1930

17 I HEREBY CERTIFY, That I attended deceased from About 1 year ago, 19 to Sep 20, 1930, that I last saw him alive on Sep 20, 1930, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): High Blood Pressure

(duration) 7 or more yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? The usual tests

(Signed) M. L. Ingram, M. D.

, 19 (Address) 2439 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: Oct. 22 1930

20 UNDERTAKER: Frederick Lassahn & Son — ADDRESS: 7401 Belair

1-30—M. & T.—100 B—50L

60740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60740

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 25-15 WARD)

2-FULL NAME Emil Puncochar 6th & Church St

(a) RESIDENCE NO 6th St. Brooklyn ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	7	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U.S. Alcohol Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Joseph Puncochar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Emma Hudlik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Louis Puncochar
(Address) 6th St. Brooklyn, Md

15 Filed ... 192 THOMPSON JONES, M. D.
2-2-1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Supra-orbital abscess
Osteo-myelitis
Accidental Death
(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Brain abscess
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at work
Did an operation precede death? Yes Date of 8/4/30 - 9/18/30
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Augur Fillers Coroner, M. D.
9/21, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemaa. DATE OF BURIAL Sept 24 1930

20 UNDERTAKER Margaret A. Flynn ADDRESS 1422 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60741

CERTIFICATE OF DEATH

129 ✓

E 60741

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 N. Wolfe ST. 8-17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane Elizabeth Neilson

(a) RESIDENCE NO. 1641 N. Wolfe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles C. Neilson

7 DATE OF BIRTH (month, day, and year) Sept. 28, 1856

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	22	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER David Hardester

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel A. Adam

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mr. Oliver W. Neilson
(Address) 1641 N. Wolfe St.

15 Filed Sep 22 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/16, 1930, to 9/14, 1930, that I last saw her alive on , 19 , and that death occurred, on the date stated above, at 9.25 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 9 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

9/19/30 (Address) 1500 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Sept. 22 1930

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60742 — 74-001 — E 60742

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1140 Cleveland St. St. 21-29 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estelle McNeal

(a) RESIDENCE NO. 1140 Cleveland St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of William O. McNeal

6 DATE OF BIRTH (month, day, and year) January 12, 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Carson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mr. William O. McNeal

(Address) 1140 Cleveland St.

Filed SEP 22 1930 H. WEST JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 19, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and from information I find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

(Coroner)

Sept. 19 30 (Address) 3601 Third St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Sept. 22 30

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 West Baltimore St

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C

E 60743

E 60743

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street, and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Sinai Memorial Hospital St., _____ Ward)

2-FULL NAME Allen Parker Jr

(a) RESIDENCE NO. 3726 Harkony Ave St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	1	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co
(State or country) Allen Park

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country)
12 MAIDEN NAME OF MOTHER Evelyn Talbott
13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Allen Parks

14 Informant Allen Parker Jr
(Address) 3726 Harkony Ave

15 Filed ..... 19.... Registrar

2 2 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Marasmus

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

(Address) 2672 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old Fel. Balto Co	Sept 23 1930

20 UNDERTAKER W. C. Brookshow ADDRESS Govans Md

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60744

CERTIFICATE OF DEATH

5 E 60744

REGISTERED NO. 9-44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2711 Montebello Terrace ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Hawkins

(a) RESIDENCE NO. 2711 Montebello Terrace ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 5 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of B. Lee Hawkins

DATE OF BIRTH (month, day, and year) Apr. 8, 1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	58	5	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER George F. Seebo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret Leibold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant B. Lee Hawkins

(Address) 2711 Montebello Terrace

Filed 9/22 1930 C. HAMPSON JONES, M. D. Registrar

2 21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4 1929 to Sept 19 1930

that I last saw her alive on Sept. 18 1930

and that death occurred, on the date stated above, at 11.20 p. m.

The CAUSE OF DEATH was as follows:

Acute Cardiac dilatation

(duration) 1 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Duodenal ulcer Hypertension (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. F. Blackburn M. D.

9/22 1930 (Address) 16 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Sept 23 1930

20 UNDERTAKER John A. Denny

ADDRESS 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

60745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

7A-001

E 60745

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1621 Race St. 23-32 St., 7 Ward)

2-FULL NAME William F. Krenz.

(a) RESIDENCE NO. 1621 Race St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced.
HUSBAND of ~~XXXD WIFE~~ of Christina Krenz.

6 DATE OF BIRTH (month, day, and year) December 1, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52	9	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania.
(State or country)

PARENTS

10 NAME OF FATHER Gotlieb Krenz.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Christina Vetter.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Christina Krenz. (wife)
(Address) 1621 Race St.

15 Filed ..... 19.. C. TIMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 18, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

9/20 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 22 1930
20 UNDERTAKER John F. Denny	ADDRESS 410 E. 25th St.

Sept 22 1930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60746

CERTIFICATE OF DEATH.

129

E 60746

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 219 N. Bruce st. (St.) 14-7 (Ward)

2-FULL NAME Maggie Blaze

(a) RESIDENCE NO. 219 N. Bruce st. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Blaze

6 DATE OF BIRTH (month, day and year) Unknown 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	62	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.... Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex Co., Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Granddaughter

(Address) Ella Beatrice Huges 219 N. Bruce st

15 Filed P 22 1930

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1st. 1930 to Sept. 19th. 1930 that I last saw h er alive on Sept. 19th. 1930 and that death occurred, on the date stated above, at 8.10p. m

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis and Mitral Ins. Of unknown origin

(duration) yrs. 7. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? NO. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Exam

(Signed) Walter D. Jackson, M. D.

, 19 (Address) 1631 W. Franklin st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cemetery

DATE OF BURIAL 9/22/1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N. Gilmor st

Spec.—1-30—M. & T.—250 Bks.

E 60747 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 60747

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 333 S. Gilmor St. (ST.) 19-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Smoot

(a) RESIDENCE NO. 333 S. Gilmor St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Smoot

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah DeGroff

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Arthur A. Ault, 333 S. Gilmor

(Address)

15 Filed 22 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/1, 1930, to 9/19, 1930, that I last saw h alive on 9/19, 1930, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (mammary) (Myocardial)

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Acute endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin M. Ober, M. D.

, 19 (Address) 2030 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 9/22/30,

20 UNDERTAKER Harry A. Mitzka. 4016 Edmondson Ave.

ADDRESS

Spec.—1-30—M. & T.—250 Blks.

Vincent Del Pizzo

E 60748

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60748

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. 6 Eastern Ave ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Delpizzo

(a) RESIDENCE NO. 1066 Eastern ST., 2nd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6a If married, widowed, or divorced, HUSBAND of or) WIFE of Albina Del Pizzo

7 DATE OF BIRTH (month, day, and year) Oct 10 1870

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59 60	11	10	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired fruit

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Del Pizzo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Albina Del Pizzo (Address) 1066 Eastern Ave

15 Filed SEP 29 19 C. J. J. JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20-30.

17 I HEREBY CERTIFY, That I attended deceased from 9-16-30, 19..... to 9-20-30, 19.....

that I last saw h.. alive on 9-20-30, 19.....

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Appendicitis

Diffuse Peritonitis

Myocarditis Hypertension

Diabetes (duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9/16/30

Was there an autopsy? No

What test confirmed diagnosis? Appendix

(Signed) M. Hendrix M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Sept 23 1930

20 UNDERTAKER H. W. & Duppel Inc — ADDRESS 37 S Amity St.

Spec.—1-30—M. & T.—250 Bks.

E 60749 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 60749

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 N. Bethel ST. 7-4 (WARD)

2-FULL NAME Alonza Lee Small

(a) RESIDENCE NO. 627 Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M.

If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Small

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Buford (State or country) N.C

10 NAME OF FATHER Thomas Small

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C

12 MAIDEN NAME OF MOTHER Mary Burris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C

14 Informant Mattie Watson (Address) 920 Aisquith St

15 Filed 2 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/20/30

17 I HEREBY CERTIFY, That I attended deceased from 9/10, 1930, to 9/20, 1930, that I last saw h.. alive on 9/20, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

Pleurisy

(duration) yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchitis & Emphysema

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. R. Blake, M. D.

9/22, 1930 (Address) 924 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery Cem.

DATE OF BURIAL 9-23 1930

20 UNDERTAKER Byrom & Wright 1218 Mc Elderry St

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60750

49 E 60750

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospital ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Sarah Harrison

(a) RESIDENCE NO. 1137 Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widowed

6a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Aug 15 1885

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
45	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Worchester Co

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) ?

12 MAIDEN NAME OF MOTHER Louisa Taylor

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) ?

14 Informant Friends

(Address) Baltimore City Hospital

15 Filed SEP 22 1930 H. LESTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20-30

17 I HEREBY CERTIFY, That I attended deceased from 6-24, 1930, to 9-20, 1930, that I last saw her alive on 9-20, 1930, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Hypertension ? Left Kidney with metastases to spine

(duration) unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of Unknown

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings

(Signed) Fred M. Dietrich M. D.

9-21, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 9-24 1930

20 UNDERTAKER Frank Schneider

ADDRESS 578 W. Fayette

Spec.—1-30—M. & T.—250 Bks

E 6075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7400

E 6075

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 Freemillow St. 17-24 WARD)

2-FULL NAME Anna Raisin

(a) RESIDENCE NO. 646 Freemillow ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1877

8 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Bucks md.

PARENTS

10 NAME OF FATHER Richard Rainie

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mariah Johns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Lucie Colleen

(Address) 646 Freemillow

15 Filed Sep 27 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1930, to Sept 19, 1930, that I last saw h[illegible] alive on Sept 19, 1930, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Cooper, M. D.

, 19 (Address) 639 Leadenhall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 9/22/30

20 UNDERTAKER: Frank Abercrombie

ADDRESS: 638 N. Bethel

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60752 202 E 60752

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hosp. St. 1-3 Ward)

2-FULL NAME Michael Staniewski

(a) RESIDENCE NO. 817 S. Glover St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 26 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Staniewski

6 DATE OF BIRTH (month, day and year) Sept 11 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town)_____

(State or country) Poland

PARENTS

10 NAME OF FATHER Casimir Staniewski

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Marcel Rogos.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Poland.

14 Informant Mary Staniewski

(Address) 817 S. Glover

15 Filed 2 2 1930 C. H. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acc. Falling & struck on head. Fradan of Skull.

(duration) 1 yrs. ___ mos. 1 ds.

CONTRIBUTORY (Secondary) Stroke

(duration) ___ yrs. ___ mos. 1 ds.

Sept 21 1930 (Signed) G E Glades M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. Date of Burial Sept. 24 1930

20 UNDERTAKER Stephen J Fralkowski INC ADDRESS 1000 S. Kenwood Ave

Spec.—1-30—M. & T.—250 Bks

60753

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 60753

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 7-11 WARD)

2-FULL NAME Marie Eckert

(a) RESIDENCE NO. 625 N. Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 23, 1930

7 AGE — Years | Months: 6 | Days: 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gone Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Leroy E. Eckert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Anna M. Rives

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Leroy Eckert (Address) 625 N. Kenwood Ave

15 Filed ..., 19... C. [illegible] JONES, M.D. Registrar

2-2-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1930, to Sept 21, 1930, that I last saw h[illegible] alive on Sept 21, 1930, and that death occurred, on the date stated above, at 12 25 P m.

The CAUSE OF DEATH* was as follows:

I. (a) Acute tracheitis (duration) yrs. mos x da.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wylie M. Faw, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Sept 23, 1930

20 UNDERTAKER: Henry Sander & Sons Inc. — ADDRESS: Baltimore St & Broadway

pec.—1-30—M. & T.—250 Bks.

E 60754 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60754

CERTIFICATE OF DEATH.

REGISTERED NO. 100-061

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1855 N. Collington Ave. ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. John Weichseldorfer

(a) RESIDENCE NO. 1855 N. Collington Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	married

6a If married, widowed, or divorced (or) WIFE of Matilda Lehrandt

6 DATE OF BIRTH (month, day, and year) 9-25-1869

7 AGE 60 Years | Months 11 | Days 27 | If LESS than 1 day, hrs. or min.

1869 Sept 28 1/2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) wood worker

(c) Name of employer Russell

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Weichseldorfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Zeklo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Matilda Weichseldorfer (Address) 1855 N. Collington Ave.

15 Filed 2 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1930. to Sept. 21, 1930.

that I last saw him alive on Sept 21, 1930

and that death occurred, on the date stated above, at 11,30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Eric L. Timmerman M. D.

9/22/30 (Address) 2157 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 9/24/30

20 UNDERTAKER George J. Puth Inc.

ADDRESS 1735 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60755 44 E 60755

CERTIFICATE OF DEATH

REGISTERED NO. 27-56

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4622 Falls Road ST. (WARD)

2—FULL NAME Minna Lassner

(a) RESIDENCE NO. 4622 Falls Road ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John Lassner

DATE OF BIRTH (month, day, and year) October 24, 1863

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Carl Gerhard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Ernest Vinghan

(Address) 1413 Cold Spring Lane

C. H. JONES, M. D.

Filed 2 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1930, to Sept 21st, 1930

that I last saw her alive on Sept 21st, 1930

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of liver

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Cancer

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 1930

Was there an autopsy? No

What test confirmed diagnosis? Findings at Operation

(Signed) C. H. Jones, M. D.

9/24, 1930 (Address) 3615 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Sept. 24 1930

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St.

239952

E 60756

HEALTH DEPARTMENT—CITY OF BALTIMORE E 60756

CERTIFICATE OF DEATH.

143-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 7-13 ST., WARD)

2-FULL NAME Josephine Jones

(a) RESIDENCE NO. 1605 E Barnes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): unknown

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June-16-1908

7 AGE — Years: 22 — Months: 2 — Days: 29 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H W

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Thos. Henry Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Anna Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

Filed SEP 22 1930, 19 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15-1930

17 I HEREBY CERTIFY, That I attended deceased from August 18, 1930, to Sept 15, 1930, that I last saw her alive on Sept 15, 1930, and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus

(duration) yrs. mos 6 hours

CONTRIBUTORY (Secondary) Thrombosis of pelvic veins.

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-4-30.

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) E. P. Davison Jr., M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL SEP 22 1930

20 UNDERTAKER Commissioner Health. ADDRESS

Per Wm E. WOODALL

Spec.—1-30—M. & T.—250 Blks.

2 f 0337 Knox. E 60757

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60757

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 9-9 (WARD)

2-FULL NAME Sam Haun

(a) RESIDENCE NO. 1017 Linden ST., ... WARD Knoxville Tenn

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 20 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

6a If married, widowed, or divorced (HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 7-3-55

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	-5	-19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of Industry, business, or establishment in which employed (or employer) Southern R/R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10 NAME OF FATHER Edmund Haun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-30

17 I HEREBY CERTIFY, That I attended deceased from 9-2-, 1930, to 9-22, 1930, that I last saw him alive on 9-22, 1930, and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate, c metastases to Pelvis bones

(duration) unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms + X ray

(Signed) Chas. C. Hewitt M. D.

9/ , 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Knoxville, Tenn

DATE OF BURIAL Sept 27 1930

20 UNDERTAKER W. J. Gibbons, Jr.

ADDRESS L-L

Spec.—1-30—M. & T.—250 Bks.

Dr. Hall 1635 E. North Ave

E 60758

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60758

CERTIFICATE OF DEATH.

4-001

14-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1333 E. North Ave (St.) (Ward)

2-FULL NAME Elvie A. Simmons

(a) RESIDENCE NO. 1333 E. North Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ or) WIFE of James A. Simmons

6 DATE OF BIRTH (month, day, and year) Sept 28th 1860

7 AGE: Years 69 | Months 11 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Margaret Tells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Mrs M. C. Lushbaugh

(Address) 1333 E. North Ave

15 Filed ~~7~~ 9 1930 19 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) Sept 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1930, to Sept 21 1930, that I last saw h[illegible] alive on Sept 21 1930, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 21 mos. ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. Gill Hall M. D.

Sept 22 1930 (Address) 1631 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chester Penna Rural Cemetery — DATE OF BURIAL 9/24/1930

20 UNDERTAKER: Wm Cook — ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 60759

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60759

CERTIFICATE OF DEATH

162

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 S. Madiera St. ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Antoni Rupinski Jr.

(a) RESIDENCE NO. 208 S. Madiera St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) Sept. 19 30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER Antoni Rupinski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine Cyryca

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant A. Rupinski
(Address) 208 S. Madiera St.

Filed 19 Registrar

21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 19 30 to Sept 22 19 30
that I last saw h alive on Sept 22 19 30
and that death occurred, on the date stated above, at 1140A m.

The CAUSE OF DEATH* was as follows:

Acute Anemia

3
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Roach, M. D.
Sept 22 19 30 (Address) 801 E Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sept. 23 1930

20 UNDERTAKER: F W Ozazewski — ADDRESS: 1930 Eastern Ave.

pec.—1-30—M. & T.—250 Bks.

E 60760

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60760

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4214 Bowers Av ST. 96-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Janssen

(a) RESIDENCE NO. 4214 Bowers Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Kontz

7 DATE OF BIRTH (month, day, and year) June 9 1898

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
32	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) United Electric R. Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W. Janssen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Augusta K. Hergsamer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Augusta K. Stafte

(Address) 4211 Bowers Av

C. HAMPSON JONES, M. D.

Registrar

Filed SEP 22 1930 19 Of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st/30

17 I HEREBY CERTIFY, That I attended deceased from June month 19 to Sept 21 19 30.

that I last saw h alive on and 2 hours ago. Sept 21 19 30 at 2 50 P. M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmon Tuberculosis

(duration) over yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? — no

What test confirmed diagnosis? —

(Signed) W. L. Riley M. D.

, 19 30 (Address) 1634 Bowers Av

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westerns Cemetery DATE OF BURIAL Sept 25 1930

20 UNDERTAKER F. A. Pleasant ADDRESS 850 W. Balto St

pec.—1-30—M. & T.—250 Bks.

E 60761 E 60761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 27-56

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Kendig

(a) RESIDENCE NO. 4919 Palmer Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Fannie Kendig

6 DATE OF BIRTH (month, day, and year) May 26 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md.

PARENTS

10 NAME OF FATHER Benjamin Kendig

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Rohrer

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Pa.

14 Informant Friends (Address) Baltimore City Hospitals

15 Filed 2 1930 19 C. HARRISON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-30

17 I HEREBY CERTIFY, That I attended deceased from 9-18, 1930, to 9-22-, 1930, that I last saw him alive on 9-22-, 1930, and that death occurred, on the date stated above, at 12 50 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of stomach

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Fred M. Ducksworth, M. D.

, 19 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashbury M. E. Cemetery DATE OF BURIAL 9-27 1930

20 UNDERTAKER J. F. Eline ADDRESS Reisterstown Md

Spec.—1-30—M. & T.—250 Bks.

D236295
D60762

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60762

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 13-52 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hans Von Marees

(a) RESIDENCE NO. Wyman Court Apt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Pauline

6 DATE OF BIRTH (month, day, and year) Aug 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Gustave

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaret [redacted]

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-21-1930

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to Sept-21, 1930, that I last saw him alive on Sept 21, 1930, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Buerger's Disease or
Thromboangiitis Obliterans

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1928-27

Was there an autopsy? Yes

What test confirmed diagnosis? Amputation

(Signed) Rawley M. Pemick Jr., M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Sept 24, 30.

20 UNDERTAKER Alexander Horner Co ADDRESS Forest Md.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60763 ✓ E 60763

CERTIFICATE OF DEATH

X 177

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St., 4-7 Ward)

2-FULL NAME Lillian J. Hutchins.

(a) RESIDENCE NO. Naragansett R.I. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —yrs. —mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): June 28, 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Soldier.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Naragansett, R.I.
(State or country)

PARENTS

10 NAME OF FATHER: John O. Hutchins.

11 BIRTHPLACE OF FATHER (city or town): .....
(State or country): Miss.

12 MAIDEN NAME OF MOTHER: Margaret E. Feeney.

13 BIRTHPLACE OF MOTHER (city or town): .....
(State or country): Washington, D.C.

14 Informant: John O. Hutchins. (brother)
(Address) Hotel Ambassador. Chicago. Ill.

15 Filed ..... 1930 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year): September 20, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Veronal poisoning, over dose.
Occidental Death.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Hotel Ornateee. Sep. 20, 1930

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

9/23 1930 (Address) 101 E. Chorles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wakefield R I.	Sept 24 /30
20 UNDERTAKER	ADDRESS
Stewart & Mowen Co	108 W. North Ave.

Important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 60764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60764

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. ... WARD) 7-4

2-FULL NAME Daisy Linton

(a) RESIDENCE NO .... Taneytown, Md. ST., ... WARD ....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Harry Linton

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Fleagle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant C. O. Fuss & Sons
(Address) Taneytown, Md.

15 2 1930 C. WILSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 22/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Septicemia due to Self induced abortion. By mechanical means

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted Probably at home
If not at place of death? ....

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? History by Dr. Elliot Taneytown, Md.

(Signed) ... Coroner, M. D.

9/22/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Taneytown Md

DATE OF BURIAL Sept 25 1930

20 UNDERTAKER C. O. Fuss & Son

ADDRESS Taneytown Md

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60765 E 60765

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Oak St ST. 12-51 WARD)

2-FULL NAME Jeanette Nash

(a) RESIDENCE NO. 2116 Oak St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 5 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
#	17	✓	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Spencer Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Sarah Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Sarah Price Nash

(Address) 2116 Oak St

15 Filed 2-3 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1930

17

I HEREBY CERTIFY, That I attended deceased from June 1 1930 to Sept 22 1930

that I last saw h alive on Sept 21 1930

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ✓ yrs. 3 mos 19 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pelletreau M. D.

9-22, 1930 (Address) 517 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 9-24 1930

20 UNDERTAKER Wm H. Chase Son

ADDRESS 1400 Madison

pec.—1-30—M. & T.—250 Bks.

E 60766 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60766

CERTIFICATE OF DEATH. × 34

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) St Josephs Hosp. ward 16-23 (Ward)

2-FULL NAME Leon Jacobs.

(a) RESIDENCE NO. 1230 Lafayette ST., WARD West Bo
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

4 COLOR OR RACE: Colored

5 Single, ~~Married, Widowed, or Divorced~~ (write the word)

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) March 2 - 1915

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15 year	6.	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Washington D.C.

10 NAME OF FATHER: Albert Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Sophia Mirsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Sophia Jacobs (Address) 1230 W. Lafayette

Filed 2-3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930, to Sept 21-, 1930, that I last saw him alive on Sept 21st, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine -

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Roy-Dennis -

(Signed) M B Gundrey M. D.

9-22, 1930 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cross Keys A. & Co Md — DATE OF BURIAL: Sept 24 1930

20 UNDERTAKER: Sim L. Chase & Son — ADDRESS: Woodlawn

Spec.—1-30—M. & T.—250 Bks.

60767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 60767

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 926 Brevard ST. 11-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Stewart

(a) RESIDENCE NO. 926 Brevard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widowed

6 If married, widowed, or ~~divorced~~ HUSBAND of or) WIFE of Saml Stewart

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Abraham ~~Foot~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md,

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Joseph H. Stewart

(Address) 926 E. Read St

Filed JUN 3 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20/30.

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930, to Sept 20, 1930, that I last saw her alive on Sept 20, 1930, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pelletcam M. D.

, 19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 9-23 1930

ADDRESS 916 Bway

20 UNDERTAKER David Taylor

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60768

CERTIFICATE OF DEATH.

129 E 60768

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1932 E. Chase St. 8-13 Ward)

2-FULL NAME George B. Alls.

(a) RESIDENCE NO. 1932 E. Chase St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah A. Alls

6 DATE OF BIRTH (month, day, and year): Dec. 22/1861

7 AGE: Years 68; Months 9; Days 29; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John P. Alls.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Philadelphia Pa

12 MAIDEN NAME OF MOTHER: Louisa Forrest

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Virginia

14 Informant: Howard Alls

(Address) 1932 E. Chase St

Filed SEP 23 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 19: September 21/30

17 I HEREBY CERTIFY, That I attended deceased from June 8 19 30, Sep 21 19 30, that I last saw h[e]r alive on Sep 19 19 30, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary): Coma

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W W White Jr M. D.

(Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem Date of Burial Sep 23 1930

20 UNDERTAKER: Frank A. Fink ADDRESS 918 N Gay St

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 60769 — 24001 — D 60769

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME George(?) or Charles(?) Holmes.

(a) RESIDENCE NO. 813 Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	unknown

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Estimated	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) unknown
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Record (Address) BALTIMORE CITY HOSPITALS

15 Filed 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1930, to Sept. 19, 1930, that I last saw him alive on Sept. 19, 1930, and that death occurred, on the date stated above, at 12:35 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Paul Padget M. D.

9-21, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL Sept 23, 1930

UNDERTAKER Chas. H. Johnson ADDRESS N. Carolina Ave

pec.—1-30—M. & T.—250 Bks

60770 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60770

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Julius Chase

(a) RESIDENCE NO. 1610 Riggs Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Male~~ ~~Female~~	Colored	Widowed

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of Susie

7 DATE OF BIRTH (month, day, and year) Feb. 18, 1877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Odd jobs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Macon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

Filed 9-3 1930 HAMPER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20-30

17 I HEREBY CERTIFY, That I attended deceased from 9-9-30, 19 , to 9-20-30, 19 ,

that I last saw h in alive on 9-20-30, 19 ,

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Vogel, M. D.

9-22 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Co Md.

Young's Chapel

UNDERTAKER Thomas E. Kelson

DATE OF BURIAL 9/24 1930

ADDRESS 1303 Fiesterman St

pec.—1-30—M. & T.—250 Bks.

E 60771

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60771

105

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 320 E. 23rd ST. 12-50 WARD)

2-FULL NAME Louisa Winston

(a) RESIDENCE NO. 320 E. 23rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of Robert Winston

DATE OF BIRTH (month, day, and year) January 1877

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

PARENTS

14 Informant Mary Jones

(Address) 320 E. 23rd St. Balto Md

15 Filed SEP 23 1930 Registrar

J. THAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930 to Sept 20, 1930

that I last saw h[illegible] alive on Sept 19, 1930

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) yrs. mos 40 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No Physical signs

What test confirmed diagnosis?

(Signed) W. H. Pearce M. D.

Sept 23 1930 (Address) 2105 Chaile st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Sept 23 1930

UNDERTAKER Wm. R. G. Elliott

ADDRESS 1315 Baltimore

Spec.—1-30—M. & T.—250 Blks. Dr Franklin 9 E. Biddle st

E 60772 HEALTH DEPARTMENT—CITY OF BALTIMORE 1001 E 60772

CERTIFICATE OF DEATH.

REGISTERED NO. 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Ottarbein St. 18-29 WARD)

2-FULL NAME Marion Guy

(a) RESIDENCE NO. 58 Ottarbein ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) Aug 19th 1930

8 AGE — Years: — Months: 1 — Days: 3 — If LESS than 1 day.....hrs. or.....min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nil

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

11 NAME OF FATHER Eugene Guy

12 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

13 MAIDEN NAME OF MOTHER Lottie Hackett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Md

14 Informant Mrs Eugene Guy

(Address) 508 Ottarbein St.

15 SEP 23 1930 19 H. RAMSAY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Monday 22, 1930, that I last saw her alive on Sept 21, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar, Left, Lower

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? none

(Signed) H. Ramsay Jones M. D.

, 19 (Address) 9 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Providence Church Cemetery — DATE OF BURIAL: 9/23/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

1-30—M. & T.—100 B—50L

E 60773

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60773

CERTIFICATE OF DEATH

179

REGISTERED NO. .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Pres Hosp ST., 4-25 WARD)

2-FULL NAME Vesta Annie Jordan

(a) RESIDENCE NO. 773 W Saratoga ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	5	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William Harris

11 BIRTHPLACE OF FATHER (city or town) St Louis
(State or country) Missouri

12 MAIDEN NAME OF MOTHER Henrietta Jordon

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Irene Williams

(Address) 723 W. Saratoga St

Filed 2-3-1930 192 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Burns Flaming nitro molasses

Burns 3rd Degree

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 723 W Saratoga

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H C Wades, M. D.
Coroner

19 (Address) 1426 Busay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL Jan 24, 1930

20 UNDERTAKER Mrs Katie R Williams

ADDRESS 3224 Edmondson Ave

pec.—1-30—M. & T.—250 Bks

E 60774

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60774

CERTIFICATE OF DEATH.

12-51 74-001

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 308 W 28 ST. (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE NO. 308 W 28 ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of Emma Smith

7 DATE OF BIRTH (month, day, and year) Feb 1876

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	60	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Hampton Smith
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va
12 MAIDEN NAME OF MOTHER Charlotte Jones
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Emma Smith
(Address) 308 W 28th

15 Filed 2-3 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1 1930 to Jan 31 1930
that I last saw h alive on Jan 31 1930
and that death occurred, on the date stated above, at 11-45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) Sudden yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. Hampson Jones M. D.
(Address) 1112 N. Eutaw St
19 2-3 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Va
DATE OF BURIAL Feb 7 1930
UNDERTAKER Harry Bloomsley
ADDRESS 378 N Biddle

Spec.—1-30—M. & T.—250 Bks

E 60775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146

E 60775

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4-N WARD)

2-FULL NAME Catherine Coleman

(a) RESIDENCE NO. 314 Myrtle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6 If married, widowed, or divorced (~~HUSBAND~~ of or) WIFE of Laurence Coleman

DATE OF BIRTH (month, day, and year) —1902

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Thos Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maggie Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

4 Informant Laurence Coleman (Address) 314 Myrtle Ave

5 Filed SEP 23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 22, 1930.

that I last saw h[illegible] alive on Sept 22, 1930

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

General sepsis

secondary to a miscarriage

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Sepsis (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-9-30

Was there an autopsy? yes Blood culture

What test confirmed diagnosis?

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvery

UNDERTAKER Orlin H. Goodwin

DATE OF BURIAL Sept 24 1930

ADDRESS 1027 Druid Hill Ave

pec.—1-30—M. & T.—250 Bks.

60776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-002
154 E 60776

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. South Baltimore Gen Hospital ST. WARD
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Digorolamo

(a) RESIDENCE NO. 214 N. Ireton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): —

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of —

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Chas A. Digorolamo

11 BIRTHPLACE OF FATHER (city or town) (State or country) It.

12 MAIDEN NAME OF MOTHER Mary Kitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Chas A. Digorolamo
(Address) 3231 Brighton St.

15 Filed SEP 23 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-30

17 I HEREBY CERTIFY, That I attended deceased from 9-18, 1930, to 9-22, 1930,
that I last saw her alive on 9-22, 1930,
and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) ....yrs. ....mos 4 ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Physical Signs
What test confirmed diagnosis?
(Signed) Joseph S. Faulkner M. D.
, 19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral
DATE OF BURIAL: 9/23/30
20 UNDERTAKER: Harry A. Smith
ADDRESS: 410 E. Lexington

Spec.—1-30—M. & T.—250 Bks

E 60777 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60777

CERTIFICATE OF DEATH. 113

REGISTERED NO. 21-37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 Cornwall ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Graham

(a) RESIDENCE No. 437 Cornwall ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 4th 1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Leroy B. Graham

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Bertha K. Revell

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Leroy B. Graham (Father) (Address) 437 S. Cornwall St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22nd, 1930, to Sept. 23rd, 1930, that I last saw h~ alive on Sept. 22nd, 1930, and that death occurred, on the date stated above, at 1 30 a. m.

The CAUSE OF DEATH* was as follows:

Enteritis

Following

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Emmett J. Feeney, M. D.

Sept 23, 1930 (Address) 1400 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Sept. 25 1930

20 UNDERTAKER Lilly & Gilen Inc.

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks.

109-002

E 60778

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60778

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. ST. 27-41 WARD)

2-FULL NAME Katherine Kaufman

(a) RESIDENCE NO. 4128 Moravia Ave. ST., 28 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Milton Kaufman

DATE OF BIRTH (month, day, and year) Aug. 20th 1898

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32 ?	1	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Joseph Trabert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Roth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Milton Kaufman (Husband)
(Address) 4128 Moravia Ave

15 Filed SEP 23 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 21, 1930, that I last saw h.e.r. alive on Sept 21, 1930, and that death occurred, on the date stated above, at 12:30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 7 days

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton Blum, M. D.

, 19 (Address) 3 mo. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemt.

DATE OF BURIAL Sept 24/30

20 UNDERTAKER Lilly & Zeiler Inc. 403

ADDRESS S. Wolfe St

pec.—1-30—M. & T.—250 Bks.

Zawadzki

E 60779 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60779

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH St. Josephs Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1-3 Caroline & Aves ST. WARD)

2-FULL NAME Virginia Zawadzki

(a) RESIDENCE NO. 2212 Bank ST., WARD (If non-resident give city or town and State)

(Usual place of abode) How long in U. S., If of foreign birth? 17 yrs. mos. ds.

Length of residence in city or town where death occurred 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Boleslaw Zawadzki

DATE OF BIRTH (month, day, and year) Jan 4 1898

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	8	17 18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland.

10 NAME OF FATHER Antoni Kasyska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Boleslaw Zawadzki

(Address) 2212 Bank St

15 Filed Sept 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1930, to Sept. 22, 1930, that I last saw h er alive on Sept. 22, 1930, and that death occurred, on the date stated above, at 4 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds. (?)

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M S Kendrick, M. D.

, 19 (Address) 1 E Preston Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery DATE OF BURIAL Sept 25th 1930

20 UNDERTAKER George A Weber ADDRESS 705 S Amity St.

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60730 90 E 60730

CERTIFICATE OF DEATH.

REGISTERED NO. 95-67

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2920 Wallbrook Ave. ST. 95 WARD

2-FULL NAME Ella Engle Fisher

(a) RESIDENCE NO. 2920 Wallbrook Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of Elbert Warfield Fisher

DATE OF BIRTH (month, day, and year) Mar. 22, 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	6	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Wm. Engle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fred'k Co. Md.

12 MAIDEN NAME OF MOTHER Frances C. Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Lillian M. Fisher

(Address) 2920 Wallbrook Ave.

15 Filed P 23 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Sept 23, 1930,

that I last saw h[illegible] alive on Sept 22, 1930,

and that death occurred, on the date stated above, at 1.30 a.m. D.S.,

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos da.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) H. H. Collins M.D.

19 (Address) 2757 Co. Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lisbon Md.

DATE OF BURIAL Sept 25 1930

20 UNDERTAKER Wm. Hudkins Sons

ADDRESS North & Pa

Spec.—1-30—M. & T.—250 Bks

E 60781

60781

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 1900 McKean Ave ST. 15-21 WARD)

2-FULL NAME S. Jennie Dallinger

(a) RESIDENCE NO. 1900 McKean Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of George N. Dallinger

7 DATE OF BIRTH (month, day, and year) Dec. 19, 1852

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Dallas Co.
(State or country) Md.

10 NAME OF FATHER John C. Zouck

11 BIRTHPLACE OF FATHER (city or town) Dally Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Stockslader

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Gertrude Stockslader
(Address) 1900 McKean ave.

15 Filed Sept 23 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 22 1930, to Sept 22 1930.
that I last saw h alive on Sept 22 1930
and that death occurred, on the date stated above, at 1065 P.M. S.T.

The CAUSE OF DEATH was as follows:
Rectal Carcinoma

(duration) 1 yr. ..... mos ..... da.
CONTRIBUTORY (Secondary) Cardio Sclerosis
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? ..... Date ..... Sept 22 1930
Was there an autopsy? ..... yes
What test confirmed diagnosis? ..... Sept 22 1930

(Signed) H. C. Hamm M. D.
(Address) 1946 McKean Ave

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Oxford Pa
DATE OF BURIAL Sept. 24 1930

20 UNDERTAKER W. H. Tucker & Sons
ADDRESS New Oxford Pa

pec.—1-30—M. & T.—250 Bks

E 60782 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60782

90

CERTIFICATE OF DEATH.

REGISTERED NO. 15-61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 Garrison ST., WARD)

2-FULL NAME Catherine Tipton Hartman

(a) RESIDENCE NO. 2608 Garrison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rev. Hubert P. Hartman

DATE OF BIRTH (month, day, and year) June 29 1873

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	7	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

BIRTHPLACE (city or town) Gettysburg
(State or country) Penna

10 NAME OF FATHER Jno. N. Tipton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Lydia E. Pocock

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna

14 Informant Rev. Hubert P. Hartman
(Address) 2608 Garrison Av

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1928 to Sept 22. 1930

That I last saw h[illegible] alive on Sept 21 1930

and that death occurred, on the date stated above, at 7[illegible] a.m.

The CAUSE OF DEATH* was as follows:

Coronal Adenoma - Cardio Vascular. Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis:

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Oscar F. Schumpert M. D.

9/23 1930 (Address) 2806 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chambersburg Pa

DATE OF BURIAL Sept 24 1930

20 UNDERTAKER H. J. Thompson

ADDRESS Monroe

HAMPSON JAMES, M. D.

1-30—M. & T.—100 B—50L

E 60783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1888 V 103

E 60783

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. G Johns Hopkins Hosp ST., WARD)

2-FULL NAME Glen Odey

(a) RESIDENCE NO. Dont Know ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	17			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dont Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant .....

(Address) .....

15 Filed 3 1930 C. HAMPSON JONES, M. D. Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: While riding atop truck struck overhead bridge

(duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore & PRR

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Feinblatt, M. D. (Coroner)

1930 (Address) 29 34 mc 8 Eday

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL SEP 2 1930

20 UNDERTAKER Commissioner Health

ADDRESS

per Wm. E. WOODALL

Spec.—2-29-28—L. F. S.—500 Blks.

E 60784½ E 60784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

REGISTERED NO. 2333

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 E. Hamburg ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence Joseph VanDitta

(a) RESIDENCE NO. 12 E. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) June 3 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Lawrence N. VanDitta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs. Lawrence N. VanDitta

(Address) 12 E. Hamburg St.

Filed 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Sept. 22, 1930, that I last saw him alive on Sept. 22, 1930 and that death occurred, on the date stated above, at 7.05 A. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. C. Campbell M. D.

9/23 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL Sept 24 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

pec.—1-30—M. & T.—250 Bks.

E 60785 E 60785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) 17-24 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joyce Cooper

(a) RESIDENCE NO. 1546 St. Mary's ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Infant-

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Oct-6-1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Alfred Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Florence Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed SEP 23 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-18-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept-13, 1930 to Sept-18, 1930.

that I last saw her alive on Sept-18, 1930,

and that death occurred, on the date stated above, at 3:20 p. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pneumonia.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 15

Was there an autopsy? Yes.

What test confirmed diagnosis? Culture of pus.

(Signed) J. C. Goodwin, M. D.

9/21, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 23 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

pec.—1-30—M. & T.—250 Bks

E 60786 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60786

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 14-20 ST., WARD)

2-FULL NAME James Thomas

(a) RESIDENCE NO. 1914 N. Bruce St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Divorced

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 12-?-1905

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	9		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Bud Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Florence McKenzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address)

15 Filed ..... 19 ..... By ..... Registrar

C. HAMPSON JONES, M. D.

3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18/30

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to September 18, 1930, that I last saw h[illegible] alive on September 18, 1930, and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Sputum Examinations

What test confirmed diagnosis?

(Signed) David Jenner, M. D.

9/18/30 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 23 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

E 60787 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60787

CERTIFICATE OF DEATH. X 31

1-PLACE OF DEATH St Agnes Hospital REGISTERED NO. 25-72

CITY OF BALTIMORE: (No. Caton & Wilkens Ave WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claudius Gillis

(a) RESIDENCE NO. 204 Walnut Ave ST., Salisbury Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Duncan J.

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 57 Months Days If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone cutter

(b) General nature of Industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury Md

PARENTS

10 NAME OF FATHER Geo B. Gillis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza J. Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Gillis (Address) 204 Walnut ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-23 — 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-7, 1930, to 9-23, 1930, that I last saw h[illegible] alive on 9-23, 1930, and that death occurred, on the date stated above, at 4 30 a m. Sunday

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) (?) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Hjalmar S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury Md DATE OF BURIAL Feb 25 1930

20 UNDERTAKER [illegible] ADDRESS [illegible]

3 1930 C. HAMPSON JONES, M. D. Registrar

pec.—1-30—M. & T.—250 Bks.

E 60788 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60788

CERTIFICATE OF DEATH.

1-001

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Co Baltimore Gen Hosp ST. 24 WARD 33

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME mrs Della Schaffer

(a) RESIDENCE NO. Bloomfield Farm ST. Balto County WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mr Schaffer

DATE OF BIRTH (month, day, and year) Aug 20 1889

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	1	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Carroll Co Md

10 NAME OF FATHER James Ester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs Della Schaffer Reisterstown Md

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1930, to Sept 23, 1930, that I last saw her alive on Sept 23, 1930, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 17 ds.

CONTRIBUTORY, (Secondary) Hemorrhage (Intestines)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Bloomfield Farm as above

Did an operation precede death? no Date of

Was there an autopsy? no Viral

What test confirmed diagnosis?

(Signed) Wm J. Sullivan, M. D.

, 19 (Address) Co Balti Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Union Cemetery

DATE OF BURIAL Sept 26 1930

20 UNDERTAKER Carroll Co ADDRESS J. F. Eckard Reisterstown Md

Rec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60789

CERTIFICATE OF DEATH

57

E 60789

REGISTERED NO. 11-24

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1219 Park Ave ST. (WARD)

2—FULL NAME Martha Rose

(a) RESIDENCE NO. 1219 Park Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fem.

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or ~~divorced~~ (or) WIFE of: Wm. Rose

DATE OF BIRTH (month, day, and year): 1875

AGE: Years 55 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant: William Rose

(Address) 1219 Park Ave

Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

2 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23/30

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to Sept. 23, 1930, that I last saw her alive on Sept. 23, 1930, and that death occurred, on the date stated above, at 11.20 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank B. Wagner M. D.

9/28, 1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. L. Lubman — DATE OF BURIAL: 9/25 1930

20 UNDERTAKER: Saml. H. Chase & Son — ADDRESS: 140 W Mosher

1-30—M. & T.—100 B—50L

E 60790

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60790

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Prov. Hospital

CITY OF BALTIMORE: (No. 14-20 ST., 11 WARD)

2-FULL NAME Rosie Hemsley

(a) RESIDENCE NO La Platte Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) La Plata Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) La Plata Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) La Plata Md
(State or country)

14 Informant Hospital Records
(Address) .....

15 Filed 3 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1920

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tonsilitis
Ruptured

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen Peritonitis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? La Platte Md

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy Ex

(Signed) J C Wades, M. D. Coroner

, 19 (Address) 143 W Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additioonal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL La Plata, Md

DATE OF BURIAL 9-24 1920

ADDRESS .....

20 UNDERTAKER Jas. M. Skinner 1625 E. Broad St

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60791 129 E 60791

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 811 E- 33d ST. 9-46 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Schaefer.

(a) RESIDENCE NO. 811 E- 33d St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime mos. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Marie Schaefer.

DATE OF BIRTH (month, day, and year) June 27/1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	23.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) / 015

(c) Name of employer ✓

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Geo. Schaefer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Dreaning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Lewis H. Audubon Jr.

(Address) 811 E 33rd St.

Filed 9 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22-30

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 1930, to Sept 22, 1930

that I last saw him alive on Sept 21, 1930

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Edronic Stephlitis

(duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ✓ yrs. 2 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) Geo. C. Shannon, M. D.

9/24 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem

DATE OF BURIAL 9/27 1930

20 UNDERTAKER I. Few McCully

ADDRESS 130 E. Fort

...—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60792 — E 60792

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 417 N. Carlton ST. 19-th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos. F. Stewart

(a) RESIDENCE NO 417 N. Carlton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal.	Col	Widowed

If married, widowed, or divorced
HUSBAND of (or) WIFE of Isabel Stewart

DATE OF BIRTH (month, day, and year) Aug 1878

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Annapolis Sand & Gravel Co

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Alexander Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Middleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Wm Stewart

(Address) 417 N. Carlton

Filed SEP 24 1930 19... Registrar C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Neck

(dutation) ... yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Poole Coroner M. D.

Sept 23 1930 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 25 1930

20 UNDERTAKER Lawrence E. Wright

ADDRESS 700 N Carrollton Ave

Dec.—1-12-23—M&T—500 Blks.

E 60793 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60793

CERTIFICATE OF DEATH.

REGISTERED NO. 28-66

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5107 Maple Park Ave ST., 28th WARD)

2-FULL NAME Charles J. Liebno

(a) RESIDENCE NO. 5107 Maple Park Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina N. Liebno

7 DATE OF BIRTH (month, day, and year) May 13, 1851

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	79	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (07)

(b) General nature of industry, business, or establishment in which employed (or employer) Wheelwright

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Julius Liebno

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Wilhelmina N. Liebno

(Address) 5107 Maple Park Ave

15 Filed SEP 24 1930 C. HAMPSON JONES, M. D. Registrar

by .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1928, ~~1930~~, to Sept 22, 1930, that I last saw him alive on Sept 22, 19 30 and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1928

Was there an autopsy? Colostomy

What test confirmed diagnosis? Observation

(Signed) A. C. Lemmon, M. D.

(Address) 409 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery — DATE OF BURIAL Sept 25 1930.

20 UNDERTAKER John A. Henry — ADDRESS 715 Light St.

Cor.—10-10-29—A Co.—100 Bks.

60794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

184-103

E 60794

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hosp St. W 30 Ward)

2-FULL NAME Alice Nugent

(a) RESIDENCE NO. Wells Ave Ferndale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 3-1923

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	7		20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Julius H Meyer

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Alice E Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Julius H Meyer
(Address) Wells Ave Ferndale

15 Filed 4 1930 C. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Ran into street into the front (path) of moving auto

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

Ruptured Spleen (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Courtland St m Paulson

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L D Frame, M. D.

9/24 1930 (Address) 2934 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loyola Park — DATE OF BURIAL Sept 25 1930

20 UNDERTAKER F Vernon Kechner — ADDRESS Hollins 153

ec. 2-29-28—L. F. S.—500 Bks.

E 60795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 60795

REGISTERED NO. 15-61

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 3623 Liberty Heights St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Lee Simmons

(a) RESIDENCE NO. 3623 Liberty Hgts St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if foreign birth? 76 yrs. 10 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	W	widow

If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Joseph Simmons

DATE OF BIRTH (month, day, and year) Nov 20th 1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	20	

OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Harford Co Md

10 NAME OF FATHER John Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Mary Thurman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

Informant Mary L. Brayden

(Address) 3623 Liberty Hgts

Filed 2 4 1930 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1930, to Sept 22nd, 1930, that I last saw her alive on Sept 22nd, 1930, and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clint A. Newell, M. D.

19 (Address) 3523 Liberty Hgts Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampden Cemetery

DATE OF BURIAL Sept 25 1930

20 UNDERTAKER Howard K McCann

ADDRESS Hampden

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60796 ×197 E 60796

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Standard Oil Building. St. 11-7 Ward)

2-FULL NAME Maxwell C. Eyers.

(a) RESIDENCE NO. Frederick Rd. Catonsville. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ~~dys.~~ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Janet Mc Culloch.

6 DATE OF BIRTH (month, day, and year) February 2, 1878.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work President N. Wo. R. R. Co.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania.
(State or country)

PARENTS

10 NAME OF FATHER John M. Eyers.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Caroline Lewis.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania.

14 Informant Janet M. Eyers. (wife)
(Address) Frederick Rd. Catonsville.

15 Filed ..... C. HAMPSON JONES, M. D. Registrar
1930 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Homicide.

Internal Hemorrhage due to pistol shot wounds of chest and abdomen inflicted by bullets fired from a pistol held in the hands of Dudley G. Gray who after-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) wards commited suicide.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.
9/24 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Point Pleasant, W. Va.

DATE OF BURIAL Sept. 28 1930

20 UNDERTAKER John C. Mitchell & Sons. 1900 Eutaw Pl.

ADDRESS

John C. Mitchell

Spec. 1-30—M. & T.—250 Blks.

60797

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

60797

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 328 S. Stricker St. ST. 19-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Coale Frederick

(a) RESIDENCE NO. 328 S. Stricker St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 14, 1890.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40		9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Binder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Jacob H. Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie M. Dowling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Annie M. Frederick

(Address) 328 S. Stricker St.

15 Date received 10-4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1930, to Sept 22, 1930, that I last saw him alive on Sept 22, 1930, and that death occurred, on the date stated above, at 10 30 AM

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Chronic Valvular Heart Disease

(Mitral Stenosis)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) C. Kelly Hemmeter M. D.

9/24, 1930 (Address) 2000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL 9/25/30

20 UNDERTAKER Harry Klitzke, 4101 E. Monument Ave.

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60798 E 60798 170 ✓

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital. St., 12-49 (Ward)

2-FULL NAME Dudley Guy Gray.

(a) RESIDENCE NO. Eden Hall, 8401 Greenway. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married

5a If married, widowed or divorced HUSBAND of Katherine Gray.

6 DATE OF BIRTH (month, day, and year) May 15, 1869

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	4	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Vice President.
(b) General nature of industry, business, or establishment in which employed (or employer) B. Md. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Columbus, Ohio
(State or country)

PARENTS

10 NAME OF FATHER William Gray.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Columbus, Ohio.

12 MAIDEN NAME OF MOTHER Virginia Beckwith.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Columbus, Ohio.

14 Informant Katherine Gray. (wife)
(Address) Eden Hall, 8401 Greenway

15 Filed SEP 27 1930, 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 23, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide.

Internal Hemorrhage due to self inflicted pistol shot wound of the chest after shooting and killing Maxwell C. Eyers.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Standard Oil Bldg. Sept. 23, 1930

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Fernhardt, M. D.

9/24, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbus, Ohio

DATE OF BURIAL 9/24 1930

20 UNDERTAKER Henry W. Mears & Sons

ADDRESS 1715 N. Calvert

Via Penn. Railroad Escort - Mrs. Catherine L. Gray

Spec.—1-30—M. & T.—250 Bks.

E 60799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60799

REGISTERED NO. 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bauer

(a) RESIDENCE NO. 516 S. Stricker St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Margaret Bauer

DATE OF BIRTH (month, day, and year) May. 1898

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	7		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agt. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Frederick Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Emma Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Margaret Bauer

(Address) 516 S. Stricker St.

Filed SEP 24 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1930, to Sept 24, 1930; that I last saw h... alive on Sept 21, 1930, and that death occurred, on the date stated above, at 2 30 (p) m.

The CAUSE OF DEATH* was as follows:

Influenza

Fatal abscess

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Influenza, cerebro spinal meningitis, pneumonia, rheumatism (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 15, 1930

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem

DATE OF BURIAL Sept 27, 30

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

Rec.—1-30—M. & T.—250 Blks.

E 60800

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60800

49

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp ST., 6-9 (WARD)

2-FULL NAME Frederick Kresbach

(a) RESIDENCE NO. 1746 Orleans St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of Margaret V Kresbach

DATE OF BIRTH (month, day, and year) 2/17/1863

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	7	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse shoer.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer self

BIRTHPLACE (city or town) Balto
(State or country)

10 NAME OF FATHER Anton Kresbach

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Braun

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs Margaret Kresbach
(Address) 1746 Orleans St

15 Filed ..... 19 ..... HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 23, 1930, that I last saw h..... alive on Sept 23, 1930, and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate gland
?
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pneumonia
(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Sept 16, 1930

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Archer Abbott Asher, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Sept 26 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60801

E 60801

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 111 S. Curley ST. 1-2 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Reiche

(a) RESIDENCE NO. 111 S. Curley St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of late Henry W. Reiche

DATE OF BIRTH (month, day, and year) Oct 3/65

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	11	20	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Cecil

10 NAME OF FATHER Henry Debus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Harry E. Hunt
(Address) 111 S Curley St

15 Filed 2 4 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23/30

17 I HEREBY CERTIFY, That I attended deceased from August 22, 1930, to Sept. 23, 1930, that I last saw h[er] alive on Sept. 22, 1930, and that death occurred, on the date stated above, at 5-15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm D Schmitt, M. D.

, 19 (Address) 701 N. Fairwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL 9/25 1930

ADDRESS 2016 Orleans St.

20 UNDERTAKER Philip Herrig

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60802

CERTIFICATE OF DEATH.

49 E 60302

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3005 Frederick Ave ST. 20-10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A. Schoenfelder

(a) RESIDENCE NO. 3005 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena L. Schoenfelder

6 DATE OF BIRTH (month, day, and year): Sept. 24-18-1863

7 AGE: Years 66 Months 11 Days 30 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hair Spinner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Charles Schoenfelder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Augusta Siegm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mrs Lena L. Schoenfelder (Address) 3005 Frederick Ave.

15 Filed 9 24 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from October 1st, 1929, to Sept 23rd, 1930, that I last saw him alive on Sept 22nd, 1930, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma

(duration) 1 yrs. mos 2 days

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 20th 1930

Was there an autopsy? No

What test confirmed diagnosis? laboratory exam

(Signed) L. B. Turnbaugh M. D.

9/23/1930 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery DATE OF BURIAL: 9/26/1930

20 UNDERTAKER: George L. Schwab ADDRESS: 2011 Eutaw Ave

-30—M. & T.—100 B—50L

E 60803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 90 V E 60803

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2108 Hollins St. 90-69 (WARD)

2-FULL NAME Andrew W Gibson

(a) RESIDENCE NO. 2108 Hollins ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Lucy V. Gibson

6 DATE OF BIRTH (month, day, and year) Feb. 19-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	7	4 5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lineman
(b) General nature of industry, business, or establishment in which employed (or employer): C. & P. Telephone Co 624
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm J. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Magers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm A. Metcalf

(Address) 886 W. Lombard

15 Filed Sept 24 1930 CHAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. A. Brune, M. D. Coroner

Sept. 25 1930 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Sept. 26 1930

20 UNDERTAKER: George L. Ashwell — ADDRESS: 2101 Eutaw Pl.

Dec.—1-30—M. & T.—250 Bks

E 60804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60804

REGISTERED NO. 154002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 813 N. Belnord Ave ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Rumel

(a) RESIDENCE NO. 813 N. Belnord Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of —

DATE OF BIRTH (month, day, and year) 9-23-30

AGE	Years	Months	Days	If LESS than 1 day, 13 hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore City

10 NAME OF FATHER John Rumel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Hilda Safranek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant (Address) John Rumel 813 N. Belnord Ave

15 Filed 4-1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24-30

17 I HEREBY CERTIFY, That I attended deceased from 9-23-30, 19..., to 9-24-30, 19...

that I last saw h.w alive on 9-24-30, 19...

and that death occurred, on the date stated above, at 4.09 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Livida

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Joseph Gallorini M. D.

9-24-1930 (Address) 2214 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cemetery

DATE OF BURIAL Sept 26 1930

ADDRESS

20 UNDERTAKER August Pasek 2406 Ashland Ave

Spec.—1-30—M. & T.—250 Bks.

60805 E 60805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Clark

(a) RESIDENCE NO. 1043 Harlem Ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

If married, widowed, or divorced HUSBAND of or) WIFE of Walter Clark

DATE OF BIRTH (month, day, and year) Dec 1890

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	9		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Anne Arundel Co Md

10 NAME OF FATHER Chas Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Walter Clark

(Address) 1043 Harlem Ave

15 Filed P 24 1930 HARRY JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept 21, 1930, that I last saw h.. alive on Sept 21, 1930 and that death occurred, on the date stated above, at 1:14 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll W St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL Mayley Jack R A Cem

DATE OF BURIAL 9/24/30

20 UNDERTAKER Edward Beck

ADDRESS 653 Harlem Ave

Dec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60806 — 001 — 122 — E 60806

CERTIFICATE OF DEATH.

REGISTERED NO. 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 S. Oldham ST., 26 WARD)

2-FULL NAME John J. McEann

(a) RESIDENCE No. 608 S. Oldham ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced (or) WIFE of Estella E. McEann

DATE OF BIRTH (month, day, and year) March 3rd 1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	49	6	17 20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dental Surgary

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Canada

10 NAME OF FATHER Daniel McEann

11 BIRTHPLACE OF FATHER (city or town) Canada (State or country)

12 MAIDEN NAME OF MOTHER Theresa McMullen

13 BIRTHPLACE OF MOTHER (city or town) Canada (State or country)

14 Informant Estella E. McEann (Wife) (Address) 608 S. Oldham St

15 Filed 9 24 1930, 19... C. HAMPSON JONES, M. Registrar. Paid

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to 9/23, 1930, that I last saw him alive on 9/24, 1930, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Lilly M. D.

9-23, 1930 (Address) (3213 Brook)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Sept. 24 1930

20 UNDERTAKER: D. Lilly + Geiler Sons

ADDRESS: 403 S. Wolfe St

...—2-29-28—L. F. S.—500 Bks.

E 60807

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 E 60807

CERTIFICATE OF DEATH

REGISTERED NO. 24-33

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 1268 Rumsey St. (WARD) 24

2—FULL NAME Carl Marsh.

(a) RESIDENCE NO. 1268 Rumsey St. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 23-30

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
			1 hr	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Roland Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Bessie M. Deems

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Bessie Marsh

(Address) 1268 Rumsey St

Filed ..., 19 ... Registrar

C. HAMPSON JONES, M. D.

24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, to Sept 23, 1930, that I last saw him alive on Sept 23, 1930, and that death occurred, on the date stated above, at 4.18 p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Mitchell, M. D.

9/23, 1930 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

20 UNDERTAKER Director of Health.

DATE OF BURIAL SEP 24 1930, 19

ADDRESS

Dec.—1-30—M. & T.—250 Bks.

E 60808

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60808

161-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Petty

(a) RESIDENCE NO. 1427 Myrtle Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

If married, widowed, or divorced HUSBAND of or) WIFE of: —

DATE OF BIRTH (month, day, and year): Aug. 14/30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	4	50 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: George Petty

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Louise Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Johns Hopkins Hospital.

15 Filed ... 19... By ... Registrar

C. HAMPSON JONES, M. D.

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-14-, 1930, to 8-14-, 1930,

that I last saw him alive on 8-14-, 1930,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH[a] was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Patent ductus arteriosus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. W. Harrison Jr., M. D.

19 (Address) Johns Hopkins Hospital.

[a]State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL: SEP 24 1930

20 UNDERTAKER: Commissioner Health

By Wm. E. WOODAL

ADDRESS

ec.—1-30—M. & T.—250 Bks.

E 60809 HEALTH DEPARTMENT—CITY OF BALTIMORE 60809

CERTIFICATE OF DEATH.

REGISTERED NO. 161-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brooks

(a) RESIDENCE NO. 3 S. Register ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 15 / 30

AGE	Years	Months	Days	If LESS than 1 day, 7 hrs. 50 min.
	—	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Clara Brooks

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant (Address) Johns Hopkins Hospital.

Filed SEP 24 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16th 1930.

17 I HEREBY CERTIFY, That I attended deceased from 9-15-, 1930, to 9-16-, 1930, that I last saw her alive on 9-16-, 1930, and that death occurred, on the date stated above, at 4 20 a m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Hampson Jones, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 24 1930, 19

20 UNDERTAKER Commissioner Health. Per Wm. E. Woodall

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60810

CERTIFICATE OF DEATH

182 E 60810

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Pier No. 8 Light St. Wharf. S. 22-b Ward)

2-FULL NAME Darphus Abrahams. (C)

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Deck hand Star. New York.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed ... 19... THE MORGUE M. D.
4 1930 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 14, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Drowning.
Accidental fall from Pier No. 8 while asleep.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto Reinhardt, M. D.
9/28. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL SEP 24 1930 19

20 UNDERTAKER Health.

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

E 60311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1971 E 60311

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 612 E. Montgomery St. St., 23-31 Ward)

2-FULL NAME John H. Bradford. (C)

(a) RESIDENCE NO. 487 W. Henriette St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	30	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed SEP 24 1930 THE MORGUE C. HAMPSON JONES, M. D. Registrar
By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 18, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest and autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Internal Hemorrhage of the Lungs
Pistol shot wound of the chest.
Homicide.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy & inquest.
(Signed) Otto M. Steinhardt, M. D.
9/28, 1930 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY SEP 24 1930	19
20 UNDERTAKER Commissioner Health.	ADDRESS
For W. H. WOODALL	

cc.—1-30—M. & T.—250 Bks

60812 HEALTH DEPARTMENT—CITY OF BALTIMORE 60812

CERTIFICATE OF DEATH. 131

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.) W-7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dewey Willett

(a) RESIDENCE NO. Mutual, Calvert Co., Md. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) June 13-1900

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	3	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laste Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Ben Willett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lizzie Cragle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records (Address)

15 Filed 2 4 1930 C. HAMPSON JONES, M. D. Registrar By H H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24-30

17 I HEREBY CERTIFY, That I attended deceased from 8-21, 1930, to 9-24, 1930, that I last saw him alive on 9-24, 1930, and that death occurred, on the date stated above, at 10-19 A. m.

The CAUSE OF DEATH* was as follows:

Bilateral Hydronephrosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) J. Leyba, M. D.

9/24, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Beaches Chapel Calvert Co Md

DATE OF BURIAL 9-25 1930

20 UNDERTAKER Samuel W Clouser & Son

ADDRESS 1400 Meeches St.

...ec.—1-30—M. & T.—250 Blks.

E. 60813 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 60813

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2617 Shirley Ave. ST.) (WARD) 15-38

2-FULL NAME Alta Mendelsohn

(a) RESIDENCE NO. 2617 Shirley Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

If married, widowed, or divorced (HUSBAND of or) WIFE of Joseph Mendelsohn

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	66			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Judah M —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jessie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lewis (Address) 1439 E Balto

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24—30

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1926, to Sept 24, 1930, that I last saw h.. alive on Sept 24, 1930. and that death occurred, on the date stated above, at 3A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Hinkes, M. D.

9/25, 1930 (Address) 1320 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Herring Run	9-25-30
20 UNDERTAKER Jack Lewis, 1439	ADDRESS E Balto St

ec.—1-30—M. & T.—250 Bks

E 60814 X 90 E 60814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary (Hospital, Etc.) (WARD) 13-9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Rowe Wiggins

(a) RESIDENCE NO. 224 Market St ST., WARD Wilmington N.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May (?) 1839

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
91		4		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) (?) N. C.

10 NAME OF FATHER Thos. Rowe Hines Wiggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) H. McRay Jones 224 S. Holmes St. Wilmington N.C.

15 Filed SEP 25 1930 HARRY R. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Sept 24, 1930, that I last saw her alive on Sept 24, 1930, and that death occurred, on the date stated above, at 5:45 P. m. (E.S.T.)

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis, arteriosclerosis General (duration) years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) Oscar C Hubbard, M. D.

Sept 27 1930 (Address) 409 Cornwall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington N. C.

DATE OF BURIAL Sept 25, 1930

20 UNDERTAKER Henry Hankins & Co

ADDRESS Orchard Humboldt

c.—1-30—M. & T.—250 Bks

60815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 E 60815

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 924 W. Franklin ST. 18-7a (WARD)

2-FULL NAME Ella M. Wilkins

(a) RESIDENCE NO. 924 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Wm Wilkins

DATE OF BIRTH (month, day, and year) 1882

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Washington D.C.

10 NAME OF FATHER Joseph H. Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wm Wilkins (Address) 924 Franklin

15 Filed 2-5 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Sept 22, 1930, that I last saw h[illegible] alive on Sept 21, 1930 and that death occurred, on the date stated above, at 6-45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Probably (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Marked Hypertension (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Upshur M. D.

9/24, 1930 (Address) 17-4 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL Sept 26, 30

20 UNDERTAKER Samuel Hensley ADDRESS 928 E Belle

ec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001

161 E 60815

E 60816

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1623 Olive ST. 7332 WARD)

2-FULL NAME Infant Son of: Mr. & Mrs. Nathan J. Chronister

(a) RESIDENCE NO. 1623 Olive ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 20, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Nathan J. Chronister

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Ruth A. Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: M. Nathan J. Chronister

(Address) 1623 Olive St.

15 Filed 5 1930, 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1930 to Sept. 24, 1930, that I last saw h/M alive on Sept. 24, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature Birth
Utero Gestation
(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) ~~Utero~~ Exhaustion
(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. K. Campbell, M. D.

9/24. 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Sept 25 1930

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

H. K. JONES, M. D.

C.—1-30—M. & T.—250 Bks.

60817

HEALTH DEPARTMENT—CITY OF BALTIMORE

60817

CERTIFICATE OF DEATH.

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1508 Milleman St. 7-13 (WARD)

2-FULL NAME Hanah Parker

(a) RESIDENCE NO. 1508 Milleman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Eden Parker

DATE OF BIRTH (month, day, and year) 1850

AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	80			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ann Arundel Co. Md.

10 NAME OF FATHER Joe Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hanah Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Charles Parker

(Address) 1508 Milleman St

Filed SEP 25 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1930, to Sept 22, 1930.

That I last saw h.r alive on Sept 22, 1930.

And that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(due to) confinement to bed

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) due to Fall Contusion and sprained Hip

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? NO Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

9/24/30 (Address) 1+2y E monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 9-25 1930

20 UNDERTAKER Byron & Wright 1218 Mc Elderry St

ADDRESS

Accidental Fall Sept 14 1930 Home

ec.—1-30—M. & T.—250 Blks.

60818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001
74 E 60818

REGISTERED NO.

1-PLACE OF DEATH Woman's Hospital ST. 17-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Agatha Florence Darrington

(a) RESIDENCE NO. 2815 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced (~~HUSBAND of~~) or) WIFE of James Darrington

DATE OF BIRTH (month, day, and year) Dec. 8, 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Frederick Achey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Catherine Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston, Mass

14 Informant Paul N. Darrington (Son)

(Address) 2815 St. Paul St.

15 Filed 5 25 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 19 30, to Sept 24, 19 30

that I last saw her alive on Sept 24, 19 30

and that death occurred, on the date stated above, at 12 10 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ✓ yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) arteriosclerosis c hypertension (duration) 3 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Rudolph L. Schorb, M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	Sept 26 1930
20 UNDERTAKER	ADDRESS
John O. Mitchell	1900 Eut

...C.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60819

CERTIFICATE OF DEATH.

90 E 60819

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3003 N Calvert ST. 17-50 (WARD)

2-FULL NAME John Albert Wright

(a) RESIDENCE No. 3003 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M.

If married, widowed, or divorced HUSBAND of (or) WIFE of Adah K Wright

DATE OF BIRTH (month, day, and year) Feb 10 1876

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	54	7	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary Y.M.C.A.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Thomas Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs Adah K Wright

(Address) 3003 N Calvert

FILED SEP 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1930

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to Sept 23, 1930,

that I last saw him alive on Sept 23, 1930,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Myocardial disease

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Acute Coronary Thrombosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? N.D. Date of

Was there an autopsy? N.D.

What test confirmed diagnosis? Clinical findings.

(Signed) Chas. C. Hampson, M. D.

, 19 (Address) 2923 St Paul St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Sept 26 1930

20 UNDERTAKER W M Roulson

ADDRESS 2238 N Smith.

...C.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60820

CERTIFICATE OF DEATH.

E 60820

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hunting Park ST. 27-54 (WARD)

2-FULL NAME Lillian D. Garrett

(a) RESIDENCE NO. 2214 Arden Rd ST., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 53 yrs. 2 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of: Maurice L. Garrett

DATE OF BIRTH (month, day, and year): June 30/1877

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	53	2	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

BIRTHPLACE (city or town) (State or country): near Newark Delaware

10 NAME OF FATHER: John W. Daylett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Newark Delaware

12 MAIDEN NAME OF MOTHER: Emma Grover

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Newark Delaware

14 Informant: Mr. Edw. T. Fenlon (son-in-law)
(Address) 3214 Arden Road

15 Filed ____ 19 ____ Registrar

25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-27-30

17 I HEREBY CERTIFY, That I attended deceased from 9-23, 1930, to 9-27, 1930,

that I last saw her alive on 9-27, 1930,

and that death occurred, on the date stated above, at 5-0 m.

The CAUSE OF DEATH* was as follows:

Pneumococcic
peritonitis

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 9-23-30

Was there an autopsy? no

What test confirmed diagnosis? Clin & Operation

(Signed) Henry J. ... M. D.

, 19 (Address) Hunting Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Sept 27/30

20 UNDERTAKER: Stewart & Conn — ADDRESS: Balto

Dec.—1-30—M. & T.—250 Bks.

E 60821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-001

E 60821

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. O'Brien

(a) RESIDENCE NO. 418 E. Biddle St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of Single

DATE OF BIRTH (month, day, and year) Feb. 26 1894

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	6	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Patrick J. O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. James O'Brien

(Address) 418 E. Biddle St

15 [illegible] 1930 [illegible], Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24-1930

17 I HEREBY CERTIFY, That I attended deceased from 9-18-30, 19..., to 9-24, 19 30

that I last saw h[illegible] alive on 9-24, 19 30

and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical.

(Signed) [illegible], M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Sept 27, 1930

20 UNDERTAKER Elmer W. Conklin ADDRESS 824 E. Eager St

[illegible] HARRY COX JONES, M. D.

ec.—1-30—M. & T.—250 Bks

60822

HEALTH DEPARTMENT—CITY OF BALTIMORE

153 E 60822

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 19-15 WARD)

2-FULL NAME Wm. H. Cooper

(a) RESIDENCE NO. 1015 Warden Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Mary Cooper

DATE OF BIRTH (month, day, and year) May 23-1887

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	4	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Guard &c

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland Pen.

BIRTHPLACE (city or town) Ireland
(State or country)

10 NAME OF FATHER Henry Cooper

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Doyle

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mary Cooper
(Address) 1015 Warden Av

P 25 1930 C. HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25/30 -

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1930, to Sept. 25, 1930, that I last saw h alive on Sept 25, 1930, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cellulitis left elbow -

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Septicemia, S/by Streptococcus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Work -

Did an operation precede death? Yes Date of 9/24/30

Was there an autopsy? No -

What test confirmed diagnosis? Gen + Lab

(Signed) Henry J. Cooper, M. D.

, 19 (Address) Univ Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 9/27 1930

UNDERTAKER Chas. F. Grandstaff

ADDRESS 118 W. Mt. Royal Ave

C.—1-30—M. & T.—250 Bks

E 60823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 60823

1-PLACE OF DEATH Baltimore City Hospitals (T B) 4/30 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Patrick Hayes

(a) RESIDENCE NO. 605 Redwood st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Mch. 1, 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Switchman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Illinois

10 NAME OF FATHER Patrick Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Belle Norcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records (Address)

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1930, to Sept. 23, 1930.

that I last saw him alive on Sept. 23, 1930.

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic cardio-vascular renal disease (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Seuner, M. D.

9-24, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Decatur, Ill.

DATE OF BURIAL 10/25/1930

20 UNDERTAKER J. A. Moran

ADDRESS 3000 E. Balto. St.

Spec.–12-23-21–E.B.R.S.–400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60824 E 60824

CERTIFICATE OF DEATH.

Registered No. 16501

1-PLACE OF DEATH

City of BALTIMORE: (No. 700 E. Barney St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Pappas

(a) Residence No. 700 E. Barney St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 23, 1930

7-AGE. yrs. mos. ds. If LESS than 1 day, 4 hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, Business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER Steven Pappas

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Greece.

12-MAIDEN NAME OF MOTHER Catherine Callahan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) Steven Pappas

(Address) 700 E. Barney St.

15- Filed 2 5 1930 192 C. HERBERT JONES, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 24, 1930

17- I HEREBY CERTIFY, That I attended deceased from Sept. 23 1930 to Sept. 24 1930

that I last saw her alive on Sept 24 1930

and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Utero - Gestation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. L. Kemptorn M. D.

9/24 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C. A. Co. DATE OF BURIAL, Sept 30 1930

20-UNDERTAKER Margaret E. Flynn ADDRESS 1411 Light St.

ec.—8-16-29—L. F. S.—100 Bks.

60825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 60825

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 S. Kenwood ave ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E. Pizkonowicz

(a) RESIDENCE NO. 1114 S. Kenwood ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 21 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) Balto
(State or country) Md.

10 NAME OF FATHER Alexander Pizkonowicz

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Pauline Simkowicz

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

Informant Alexander Pizkonowicz
(Address) 1114 S. Kenwood ave

Filed C. HANSON JONES, M. D.
Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1930, to Sept. 24, 1930, that I last saw h[illegible] alive on Sept. 24, 1930 and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Entero-Colitis

(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? P. S. & Symptoms

(Signed) John V. Zegerbein, M. D.

49 (Address) 735 S. Kenwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem.

DATE OF BURIAL Sept. 25 1930

20 UNDERTAKER Stephen J. Fialkowski Inc.

ADDRESS 1000 S. Kenwood ave

rc.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60826 162 VE 60826

CERTIFICATE OF DEATH

REGISTERED NO. 20-26

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. West Baltimore Gen. Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Grimm

(a) RESIDENCE NO. 1915 Frederick Ave 410 Edmondson ST., ~~HVE~~ WARD
(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 24, 1920

AGE	Years	Months	Days	If LESS than 1 day, hrs. or 60 min.
Minutes				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Oscar H. Grimm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Oscar H. Grimm

(Address) 1915 Frederick Ave

Filed C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1920, to Sept 24, 1920,

that I last saw her alive on Sept 24, 1920

and that death occurred, on the date stated above, at 5:00 P m. DST

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Boehman M. D.

, 19 (Address) West. Balto. Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Sept 25 1920

20 UNDERTAKER Harry H. Witzke ADDRESS 410 Edmondson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60827 — 159,002 — E 60827

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Dugleland ST. (or WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Sweeney.

(Residence in Baltimore: No. 1216 Dukeland St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH Sept - 24 - (Month) (Day), 1930 (Year)

7-AGE, ...yrs. ....mos. 1 ds. If LESS than 1 day, 4 hrs. or 0 min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank J. Sweeney

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Anna Murphy

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. J. Sweeney

(Address) 1216 Dukeland St

15- Filed SEP 25 1930. H. M. JONES, M. D. Registrar. Ref.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 25 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1930, to Sept 25 1930, that I saw him alive on Sept 24 1930, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Patent Foramen Ovale

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Norbert C. Hafely M. D.

9-25, 1930 (Address) 2157 Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cem

DATE OF BURIAL. Sept 24, 1930

20-UNDERTAKER H. C. Brauning & Son

ADDRESS 1130 Poplar Grove

ec.—1-30—M. & T.—250 Bks

E 60828

E 60828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 4803 York Road ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian A. Tapscott

(a) RESIDENCE NO. 4803 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Tapscott Sr.

DATE OF BIRTH (month, day, and year) Aug 6/1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	68	1	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lancaster Co Va.

10 NAME OF FATHER William D. Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middlesex Co Va.

12 MAIDEN NAME OF MOTHER Elizabeth Pauk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William H. Tapscott Jr

(Address) 4803 York Road

15 Filed ...., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 27/30

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1928, to September 27, 1930, that I last saw h... alive on September 27, 1930, and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia.

Acute Cardiac Dilatation

(duration) yrs. mos 7 ds;

CONTRIBUTORY (Secondary) Hypertension

(duration) 4 yrs. 2 mos. 10 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John C Hanson, M. D.

, 19 (Address) 4704 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Sept 27 1930

ADDRESS

20 UNDERTAKER Henry H Amoroux & Son 4704 Ridgewood Ave

5 1930

E. CLYDE JONES, M. D.

ec.—1-30—M. & T.—250 Bks

60829 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212. Vincent St. 9-27 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Williams

(a) RESIDENCE NO. 212 Vincent ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) 9/23/30.

AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or 30 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Norman Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland.

14 Informant Mother.
(Address) 212 Vincent St.

15 Filed 25 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1930, to Sept 24, 1930, that I last saw him alive on Sept 24, 1930, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Prematur Delivery
at 36 weeks.

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Maternal Lues

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Maternal ++++ Wassermann

(Signed) Louis B. Mackay Lewis, M. D.

9/24 1930 (Address) Mer. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL SEP 25 1930

20 UNDERTAKER

ADDRESS

ec.—1-30—M. & T.—250 Bks

60830 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60830

CERTIFICATE OF DEATH. 161-069

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Riggs St. WARD) 16-22

2-FULL NAME Baby girl Malloy

(a) RESIDENCE NO. 1615 Riggs ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 9/19/30

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md
(State or country)

10 NAME OF FATHER, James Malloy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER. Laura Taylor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Northumberland Va.

I mother
Informant 1615 Riggs St.
(Address)

Filed SEP 25 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/30

17 I HEREBY CERTIFY, That I attended deceased from 9/19, 1930, to 9/20, 1930, that I last saw her alive on September 19, 1930, and that death occurred, on the date stated above, at 5 AM. m.

The CAUSE OF DEATH* was as follows:

Premature delivery at 26 weeks of pregnancy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lues maternal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? W. R. Mass.

(Signed) [illegible], M. D.

9/22, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL SEP 25 1930

20 UNDERTAKER

ADDRESS

H. HAMILTON JONES, M.

—M. & T.—100 B—50L

E 60831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

198 E 60831

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 22-30 WARD)

2-FULL NAME Warner Williams

(a) RESIDENCE NO. 600 W. Lee ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 11-1903

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	10	9	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer General Refractories

BIRTHPLACE (city or town) (State or country) N. C.

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Rachel Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Mrs. R. Williams
(Address) 600 W. Lee St.

15 Filed ..... 192 ... Registrar

5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1930.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage due to stab wound of abdomen.
Homicide.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 500 Barre St.

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Eugene Zeller Coroner, M. D.

9/22. 1930 (Address) 2737 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elizabeth City N.C. DATE OF BURIAL Sept 20

20 UNDERTAKER Joseph A Lively ADDRESS 409 N Broadway

ec.—1-30—M. & T.—250 Bks

60832 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60832

CERTIFICATE OF DEATH. 161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 536 N. Gilmor ST. 19-26 WARD)

2-FULL NAME Doris Offer

(a) RESIDENCE NO. 536 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 26 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Herbert Offer

11 BIRTHPLACE OF FATHER (city or town) Churchton (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City (State or country) Md

4 Informant Mother (Address) 536 N. Gilmor St

5 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1930, to Sept 20, 1930, that I last saw h[illegible] alive on Sept 20, 1930 and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Undernutrition, Baby would not nurse.

Malnutrition

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physical Exs

(Signed) [illegible] M. D.

Sept. 22, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL SEP 23 1930 19

20 UNDERTAKER [illegible]

ADDRESS

F. HAMPSON JONES, M.D.

SEP 23 1930

Spec.—1-10-21—M&T—1500 Bks.

E 60833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60833

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 11th WARD) 1125

2-FULL NAME Baby Boy Chatham

(a) RESIDENCE NO. 626 McCulloughs ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced; (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18. 1930

7 AGE Years Months Days 3 If LESS than 1 day, hrs. or min. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leo Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Zillia Chatham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Mother

(Address)

15 Filed 9/25 1930 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1930, to Sept 21, 1930, that I last saw him alive on Sept 21, 1930, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity (33 wks)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & Physical Exam

(Signed) [illegible] M. D.

9/25, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL SEP 25 1930 19

20 UNDERTAKER Commissioner Health.

ADDRESS

ec.—1-30—M. & T.—250 Bks.

E 60834

240920

Dr. Surg.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60834

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME Carrie Swanson

(a) RESIDENCE NO. 605 St Mary's ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

If married, widowed, or divorced
HUSBAND of
or) WIFE of —

DATE OF BIRTH (month, day, and year) 5-2-80

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	4	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Tenn.

10 NAME OF FATHER Francis Swanson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Emily Griffen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Dated 9 25 1930

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-30

17 I HEREBY CERTIFY, That I attended deceased from 9-22-, 1930, to 9-25-, 1930,

that I last saw her alive on 9-25-, 1930,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Neuroma 8th cranial nerve left

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-23-30

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Paul W Leib, M. D.

9/25 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newport, Tenn

DATE OF BURIAL Sept 26 1930

20 UNDERTAKER William G. Schaeffer

ADDRESS 816 Monument

Spec.—1-10-21—M&T—1500 Blks.

E 60835

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60835

CERTIFICATE OF DEATH.

118-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 31 (WARD)

2-FULL NAME Baby Girl Adams

(a) RESIDENCE NO. 156 W Cross ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15. 1930

7 AGE: Years | Months | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leon Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ruth Lindsay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Mother

Filed SEP 25 1930 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Sept 20, 1930, that I last saw her alive on Sept 20, 1930, and that death occurred, on the date stated above, at 6:32 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mesenteric Thrombosis

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 19. 30

Was there an autopsy? No

What test confirmed diagnosis? Typhoid Pneumonia

(Signed) [illegible], M. D.

9-23, 1930 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND DATE OF BURIAL SEP 25 1930

20 UNDERTAKER: Commissioner Health. ADDRESS

[illegible]

30—M. & T.—100 B—50L

60836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

82 E 60836

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE, No. Mazzie Railway Shipyard ST., ... WARD

2-FULL NAME Unknown

(a) RESIDENCE NO. 4 ... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced (write the word):

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 40 — Months: — Days: — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bot. asc Drowning

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Sept 24 30

What test confirmed diagnosis? Findings

(Signed) G C Lady, Coroner, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: SEP 25 1930

20 UNDERTAKER — ADDRESS

C. HAMPSON JONES, M. D.
THE MORGUE

SEP 2

c.—1-30—M. & T.—250 Bks.

B 39099 E 60837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 60837

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Jones

(a) RESIDENCE NO. 723 Marshall ST., WARD Richmond Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	unknown

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) D.C.

10 NAME OF FATHER Oliver Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

~~HAMPSON JONES, M. D.~~

Filed 25 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-24-1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to Sept-24, 1930, that I last saw her alive on Sept-24, 1930, and that death occurred, on the date stated above, at 7:15 p m.

The CAUSE OF DEATH* was as follows:

Post-operative shock following operation for Stones in left kidney

(duration) yrs. mos 2 hours ds.

CONTRIBUTORY (Secondary) Bilateral Nephrolithiasis - Pyonephrosis & Pyelitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of death.

Did an operation precede death? Yes Date of Sept-24, 1930

Was there an autopsy? No

What test confirmed diagnosis? X-rays - Cultures of urine

(Signed) H. S. Everett, M. D.

9/24, 1930 (Address) The Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond. Va

DATE OF BURIAL Sept 25, 30

ADDRESS, 027 Druid Hill

20 UNDERTAKER John H. Woodson

1-30 M. & T.—250 Bks.

Dr. H. C. Hyde

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60838 — 129 E 60838

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 E. 41st ST., 9-47 WARD)

2-FULL NAME Fannie B. Jones

(a) RESIDENCE NO. 702 E. 41st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles D. Jones

DATE OF BIRTH (month, day, and year) Aug. 23rd 1873

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	1	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) City
(State or country)

10 NAME OF FATHER Henry W. Burke

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Hester Hayward

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

Informant C. H. Jones
(Address) 308 Fairmount Ave.

Filed 5 1930 C. HAMPSON JONES, M. D. Registrar

by ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1928, to Sept 25, 1930, that I last saw her alive on Sept. 23, 1930, and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Right Side Paralysis Sequence to Arterio Sclerosis and Chronic Interstitial Nephritis (duration) unknown

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Harry C. Hyde, M. D.

9/23, 1930 (Address) 1100 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 9/26 1930

20 UNDERTAKER C. V. Fanning & Son — ADDRESS 1536 E. Lafayette Ave.

Cor.—10-10-29—A Co.—100 Bks.

E 60839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60839

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 8-17 Ward)

2-FULL NAME Charles R. Kines. Sr.

(a) RESIDENCE NO. 1514 N. Gay St. St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Fannie Kines.

6 DATE OF BIRTH (month, day, and year) June 18, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER John Kines.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Anna ----------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Charles R. Kines. Jr. (son)
(Address) 927 N. Gay St.

15 Filed ..... 19 ..... G. HAMPSON JONES, M. D. Registrar
5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 24, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Accidental Fall from bed.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1514 N. Gay St. Sept. 21, 1930

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Leinhardt, M. D.

9/25. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Marys Hampden	9/27 1930
20 UNDERTAKER Wm. Cook	ADDRESS 1211 N. Carrollton

Rec. 2-29-28—L. F. S.—500 Bks.

E 60840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-62 V E 60840

REGISTERED NO. 16-67

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Bon Secours Hospital (WARD)

2—FULL NAME William Kirkwood

(a) RESIDENCE NO. 624 Hampson St. Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 12. 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Harry E Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Katherine Wehe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Harry E Kirkwood

(Address) 624 Hampson St

C. HAMPSON JONES, M. D. Registrar

Filed 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1930 to Sept. 25, 1930

that I last saw him alive on Sept 25 1930

and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

Dysentery, Acute Bacillary

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Chas A. Sileyk M. D.

, 19 (Address) Bon Secours Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 9/28 1930

20 UNDERTAKER Wallace Cook

ADDRESS 1217 E Pratt St

c.—2-29-28—L. F. S.—500 Bks.

E 60841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-027 L

E 60841

REGISTERED NO. 16-67

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Kirkwood Jr.

(a) RESIDENCE NO. 624 Harrison Ave ST. WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced: HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year): Nov. 13. 1927

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	10	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Harry E Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Katherine Hehe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant: Harry E Kirkwood

(Address) 624 Harrison Ave

C. HAMPSON JONES, M. D. Registrar

Filed 9 25 1930 By ARB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Sept 24, 1930, that I last saw him alive on Sept 24, 1930, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery Acute Bacillary

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of None

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Chas. D. Stiles Jr., M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 9/28 1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1219 Lexington St

ec.—1-30—M. & T.—250 Blks.

E 60842 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60842

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Sinai Hosp. ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hannah Pressell

(a) RESIDENCE NO. Fort Howard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of the late Frank Pressell

DATE OF BIRTH (month, day, and year) Dec 10th 1857

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	9	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Wilmore Pa

10 NAME OF FATHER Edward F Leytle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilmore Pa

12 MAIDEN NAME OF MOTHER Eliza J Fok

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmore Pa

Informant Harry E Leytle

(Address) Fort Howard End

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, to Sept 25, 1930,

that I last saw her alive on Sept 25, 1930,

and that death occurred, on the date stated above, at 6.45 A.m. E.S.T.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis

Chronic nephritis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Ulcerative colitis (duration) yrs. mos. 12 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Morton B Kirsh, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Altoona Pa

DATE OF BURIAL Sept 27, 1930

ADDRESS 1217 St Paul St

20 UNDERTAKER Tom Cook

5-1930 C. HAMPSON JONES, M. D. Registrar

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60843

CERTIFICATE OF DEATH.

100 E 60843

REGISTERED NO. 1027

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2002 N Lexington ST.; 20 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minerva Anna Camden

(a) RESIDENCE No. 2002 N. Lexington ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed or divorced, HUSBAND of (or) WIFE of: Wm S. Camden

6 DATE OF BIRTH (month, day, and year): April 29 1856

7 AGE: Years 74 Months 4 Days 25 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Preston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: catherine allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Geneva L Davis (daughter) Elizabethtown Ky.

15 Filed 25 1930 19 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1930 to Sept 24 1930 that I last saw h er alive on Sept 24 1930 and that death occurred, on the date stated above, at 9.15A m.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia & Pleurisy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Phlebitis (duration) yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of "

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hattie E Tuckerman M. D.

9/24 1930 (Address) 2002 N Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 9/26/30

20 UNDERTAKER: P. B. Kilpatrick — ADDRESS: 1850 N. Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

E 60844

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60844

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. 20-69 St., Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Christian Foos

(a) RESIDENCE NO. 411 Fort Hill Av St., Char Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Christian Foos

6 DATE OF BIRTH (month, day, and year) April 15th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pickle Merchant
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Christian Foos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Braun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna L. Foos
(Address) 411 Fort Hill Av

C. HAMPSON JONES, M. D.
19 Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-23 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1930, to Sept 23, 1930, that I last saw him alive on Sept 23, 1930, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:
Chronic Cardio Vascular Renal disease with uremia and anemia

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests and clinical signs.

(Signed) H. Palmer S. Anderson M. D.

19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery

DATE OF BURIAL 9/26/19 30

20 UNDERTAKER F. D. Kuppuit

ADDRESS 1850 N. Balto Ln

C.—1-30—M. & T.—250 Blks.

E 60845

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60845

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2633 Frederick Rd (WARD) 20-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Dixon

(a) RESIDENCE NO. 2633 Frederick Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, ~~widowed, or divorced~~ HUSBAND of or ~~WIFE of~~ Sophia Dixon

DATE OF BIRTH (month, day, and year) Oct 27th 1851

AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	78	10	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Sophia Dixon

(Address) 2633 Frederick Rd

Date 9/25 1930 C. Harrison Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1 1929 to Sept 22 1930.

that I last saw ~~him~~ alive on Sept 21 1930, at m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility - Myocarditis

Hypostatic Lung Congestion

(duration) Hrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harold C. Hitch M. D.

9/24/30 (Address) 2132 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetery Mt Olivet Cemetery DATE OF BURIAL 9/27/30

UNDERTAKER F. B. Dippert ADDRESS 1835 W. Baltimore St

Registrar

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60846

E 60846

CERTIFICATE OF DEATH.

REGISTERED NO. 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) 23-34 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy A Keelan (KELEHAN)

(a) RESIDENCE NO. 1729 Light ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

If married, widowed, or divorced HUSBAND of or) WIFE of Mary Feeley

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Loc Ave Haven Pa

10 NAME OF FATHER Tim Keleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sarah Mc Guigan

(Address) 1729 Light St

Filed 2-5-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-30

17 I HEREBY CERTIFY, That I attended deceased from 8-28-30, 19..., to 9-23-, 19 30,

that I last saw h alive on 9-23-, 19 30,

and that death occurred, on the date stated above, at 9.00 A.m.

The CAUSE OF DEATH* was as follows:

Aneurysm of aorta (Luetic)

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? X-Ray

(Signed) M B Keeley, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 9/26 1930.

20 UNDERTAKER J. F. Tobin Sons

ADDRESS 318 Light St

...c.—2-29-28—L. F. S.—500 Bks.

E 60847

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 ✓

E 60847

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

...ITY OF BALTIMORE: (No. ST. 27-55 WARD)

2—FULL NAME Mrs Annie Fisher

(a) RESIDENCE NO. 5342 Reisterstown St. WARD
(Usual place of abode) (If non-resident give city or town and State)

...ngth of residence in city or town where death occurred 56 yrs. 4 mos. 2 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
...male	White	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank M. Fisher

...ATE OF BIRTH (month, day, and year) May 22 1874

...GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4	2	

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Duncan Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Christine Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County

Informant Hospital Record

(Address)

Filed SEP 26 1930, 19 ...T. HAMBLETON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24-1930

17 I HEREBY CERTIFY, That I attended deceased from 9-15-30, 19..., to 9-24, 1930.

that I last saw her alive on 9-24, 1930

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Adeno carcinoma of uterus Body

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 9-16-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert L. Benarde F., M. D.

..., 19 (Address) M. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL David Ridge DATE OF BURIAL Sept 27 1930

20 UNDERTAKER H. D. Marshall ADDRESS 3539 Fall Rd

Ernest R. Redding

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60848 — 38 — B 60848

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) City Hospital (ST.) 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. R. Redding

(a) RESIDENCE NO. 31 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preacher. 614

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Charlestown Md.

10 NAME OF FATHER Tisby Redding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Snowden.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant (Address) Hospital Record

Filed 2 6 1930 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-30.

17 I HEREBY CERTIFY, That I attended deceased from 8-1, 1930, to 9-22, 1930, that I last saw h[illegible] alive on 9-22, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows: [illegible] Syphilis of Central Nervous System

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cryptic (duration) yrs. 1 mos. 23 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab.

(Signed) J. Chesley Arnold Jr, M. D.

19 (Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery

DATE OF BURIAL Sept 27, 30

20 UNDERTAKER Pratt & Williams

ADDRESS 1515 McCulloh St

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 60849

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 Binney ST. 13 WARD)

2-FULL NAME Bessie Elizabeth Scott

(a) RESIDENCE NO. 903 Binney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Arthur A. Scott.

DATE OF BIRTH (month, day, and year) Sept 25 1888

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	11	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ellen Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Arthur A. Scott Husband

(Address) 903 Binney St.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 23, 1930, that I last saw h[illegible] alive on Sept 23, 1930, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. 1 wk 5 ds.

CONTRIBUTORY (Secondary) Fatty degeneration of Cardiac Muscle (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. J. Harvey M.D.

9/24 1930 (Address) 1424 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Cemetery

DATE OF BURIAL Sept 26 1930

UNDERTAKER Robt T. Williams

ADDRESS 1515 McElderry St

[illegible] 1930 HAMPSON HOKES, M. D.

C.—1-30—M. & T.—250 Bks

60850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 60850

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T. B.) ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME James Jones

(a) RESIDENCE NO. 106 W. York st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 25, 1891

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36	39	11	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore - fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 074

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Lancaster Virginia

10 NAME OF FATHER Jetter G. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louise Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) 25/30 Mt Cullen Ave

15 Filed ..., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 19 30, to Sept. 23, 19 30, that I last saw him alive on Sept. 23, 19 30, and that death occurred, on the date stated above, at 3.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Greene, M. D.

9-24 19 30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wyelodge Va DATE OF BURIAL 9-26, 19 30

20 UNDERTAKER Chas E Wright & Son ADDRESS Baltimore Md

Paul JONES, M. D.

Dec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60351 100-001 E 60351

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 718 Ajax ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertie Rogers

(a) RESIDENCE NO. 718 Ajax ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Rogers

DATE OF BIRTH (month, day, and year) Oct 5-1879

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	11	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Co. Md.

10 NAME OF FATHER Clak. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Meare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Robert Anderson

(Address) 619 Stirling St.

Filed 6-1930 H. CHAMPE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1930, to Sept 24, 1930, that I last saw her alive on Sept 24 1930 and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) I. H. Hornstein, M. D.

9/25, 1930 (Address) 733 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL Sept 28 1930

20 UNDERTAKER Chas. H. Johnson — ADDRESS 416 N. Carolina St.

...c.—1-30—M. & T.—250 Bks

E 60352 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60352

CERTIFICATE OF DEATH.

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 9-47 WARD)

2-FULL NAME Sr. M. Ignatius Gilbert

(a) RESIDENCE NO. St Elizabeth's Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) ?

AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	76 ?	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Louis Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant. Hospital Records

(Address)

Filed 1-2-31 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24-30

17 I HEREBY CERTIFY, That I attended deceased from 9-11, 1930, to 9-24, 1930, that I last saw her alive on 9-24, 1930, and that death occurred, on the date stated above, at 2 35 A m.

The CAUSE OF DEATH* was as follows:

Fracture Surgical Neck Humerus (Accidental)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? St Elizabeth's Home

Did an operation precede death? No Date of Reduction of fracture

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

9/24 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Elizabeths Home. Cem F

20 UNDERTAKER Henry W. Jenkins & Sons Co

DATE OF BURIAL 9/26 1930

ADDRESS Orchard & McCulloh

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60853

CERTIFICATE OF DEATH

44 VE 60853

REGISTERED NO. 15-63

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3623 W. Garrison Ave (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Black

(a) RESIDENCE NO. 3623 W. Garrison Ave WARD
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed or Divorced~~ (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Black

DATE OF BIRTH (month, day, and year) June 18 1843

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	3	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Fuchs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elis Kiddlach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Elizabeth Black

(Address) 3623 W. Garrison

Filed SEP 26 1930 19... BLANCHE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1930, to Sept 24th, 1930, that I last saw her alive on Sept 24th, 1930, and that death occurred, on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 5 mos. 18 ds.

CONTRIBUTORY (Secondary) Hemorrhage from stomach

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Henry Heilek, M. D.

1926, 1930 (Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Sept 27 1930

20 UNDERTAKER F. A. Blanchard & Son — ADDRESS 703 Hanover

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60854 — 129 E 60854

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkes Avenues ST., 18 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Harrell

(a) RESIDENCE NO. 1104 W. Baltimore ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josie S. Harrell

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer in Furniture

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) NC. unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Charles Harrell (Address) 1104 W. Baltimore Md

15 Filed 19 H. RIDGELY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/23 1930, to 9/24 1930, that I last saw h im alive on 9/24 1930, and that death occurred, on the date stated above, at 4:30 P.m. Standard

The CAUSE OF DEATH* was as follows:

Chronic Cardio Vascular Renal disease

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Laboratory tests Clinical Symptoms

What test confirmed diagnosis?

(Signed) Hjalmar S Anderson, M. D.

9/24 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 9/26 1930

20 UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun Holliday

...c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60855

57

60855

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE (No. 2237 E. Oliver ST. 8-16 WARD)

2-FULL NAME George H. Degenhard

(a) RESIDENCE NO. 2237 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

If married, widowed, or divorced HUSBAND) of (or) ~~WIFE~~) of Mrs. Mollie Degenhard

DATE OF BIRTH (month, day, and year) August 4 1863

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	1	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Decorator

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto - Md

10 NAME OF FATHER August Degenhard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

Informant Mr. Degenhard (Son)

(Address) 2237 E. Oliver St.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1930, to Sept 24, 1930, that I last saw ~~he~~ alive on Sept 23, 1930, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests

(Signed) Edward E. Simonds M. D.

9/24/30 (Address) 613 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 27 1930

ADDRESS St

20 UNDERTAKER Henry Hoeck & Sons

1301 E. Eager

HAMPSON JONES, M. D.

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60856 101-001 ✓ E 60856

1—PLACE OF DEATH Maryland General Hospital REGISTERED NO.

ITY OF BALTIMORE: (No. Madison Linden ST. 1622 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr Arthur Parker

(a) RESIDENCE NO. 734 No. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Syl yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 13 1912

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	11	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saboer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER [illegible] Mr. Arthur Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Mansberry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

Informant Sarah Parker

(Address) 634 N. Gilmor St.

Filed 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23. 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept 22, 1923, to Sept 23, 1923, that I last saw him alive on Sept. 23, 1930 and that death occurred, on the date stated above, at 8 P m. ST

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 24 hrs

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert N. Carter M. D.

, 19 (Address) Md. Gen. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 9/27 1930

20 UNDERTAKER Thomas E. Relson

ADDRESS 1130 Pressman ST

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60857

CERTIFICATE OF DEATH

1917 ✓ E 60857

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Hospital ST., 16-23 WARD)

2-FULL NAME Calvin Hines Owens

(a) RESIDENCE No. 613 N Calhoun ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Singl.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Bowser Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Bernetta owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. md

14 Informant Lilly Hines

(Address) 613 N. Calhoun st

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Homicide Gunshot

Heart & Lungs

(duration) Instt yrs. mos — ds.

CONTRIBUTORY (Secondary) Lock

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? Harlem Square

Did an operation precede death? — Date of

Was there an autopsy? Yes

What confirmed diagnosis? Autopsy

(Signed) J. O. Blades, M. D.
Coroner

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 9/27 19

20 UNDERTAKER Thomas E. Kelam

ADDRESS 1303 Priestman

...C.—1-30—M. & T.—250 Bks.

E 60858

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60858 114 VE 60858

CERTIFICATE OF DEATH.

REGISTERED NO. 2863

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McDermott

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Native yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Feb 8 1894	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) (?) Ireland

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland (?)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland (?)

14 Informant D. S. Gittings
(Address) Wheelers Mills, Md.

15 Filed 2 6 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1894, to Sept 25, 1930,

that I last saw h[illegible] alive on Sept 25, 1930,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Entero-Colitis

abt (duration) yrs. mos 3 or 4 ds.

CONTRIBUTORY (Secondary) Chr. Dyspepsia

abt (duration) 36 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cem

DATE OF BURIAL Sept 27 1930

20 UNDERTAKER C. E. Arthur

ADDRESS Towson Md.

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167 ✓ 001

E 60859

REGISTERED NO. E 60859

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 Halcyon Ave ST. 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Rudolph Veditz

(a) RESIDENCE NO 2603 Halcyon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Veditz

6 DATE OF BIRTH (month, day, and year) July 24/1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50.	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer) Chemicals
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Wm. Veditz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Alice Veditz

(Address) 2603 Halcyon Ave

15 Filed 192 Registrar

P 26 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 25/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Illuminating Asphixiation- Suicide (All burners of gas range on & not lighted)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Coroner, M. D.

9/25/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery Phila

DATE OF BURIAL Sept 28 1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 St Paul

...c.—1-30—M. & T.—250 Bks.

R40738 Obst. 60860 E 60860 x 129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Butler

(a) RESIDENCE NO. North Point Road, Colgate, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Female	Black	Married

If married, ~~widowed~~, or ~~divorced~~ HUSBAND OF or) WIFE OF Thomas Butler

DATE OF BIRTH (month, day, and year) Dec. 16, 1888

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	9	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) So. Carolina

10 NAME OF FATHER King Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) So. Carolina

12 MAIDEN NAME OF MOTHER Carrie Steward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) So. Carolina

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 29 1930 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) SEP 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1930, to Sept. 24, 1930; that I last saw h~~im~~ alive on Sept 24, 1930, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis, with myocarditis, as contributory cause. pneumonia infarct as immediate cause.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Edmund P. Harrison M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodbury Ct

DATE OF BURIAL Sept 27 1930

ADDRESS

20 UNDERTAKER J. L. Brown & Son 101 N. Monty

oc.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60861 × 31 VE 60861

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 1310 W. Mulberry ST., WARD) 14-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Broadway

(a) RESIDENCE NO. 1310 W. Mulberry ST. WARD Dev. 9

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Jesse Broadway

DATE OF BIRTH (month, day, and year) 4-15-1907

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	5	10	9

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Eastman Ga

10 NAME OF FATHER Walter Brazeal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastman Ga

12 MAIDEN NAME OF MOTHER Catherine Curry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jeffersonville Ga.

Informant Brother in Law

(Address) 310 W Mulberry

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24-30

17 I HEREBY CERTIFY, That I attended deceased from 7-25, 19 30, to 9-23, 19 30

that I last saw h alive on 9-23, 19 30

and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) T. B. empyema (duration) yrs 10 mos. ds.

18 Where was disease contracted if not at place of death? In Clev. O.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Luther X. Dultz, M. D.

, 19 (Address) 1404 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Sept 27 19 30

ADDRESS

20 UNDERTAKER C. L. Brown & Son

ec. 2-29-28—L. F. S.—500 Bks.

E 60862 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 60862

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 2902 Parkwood ave ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Lovett

(a) RESIDENCE NO. 2902 Parkwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ David

DATE OF BIRTH (month, day, and year) Unknow

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0 37

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Joseph Lovett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fagie -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Harry Lovett

(Address) 2902 Parkwood ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26/30

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1917 to Sept 26, 1930, that I last saw h alive on Sept 26, 1930 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemmorhages

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cholelithiasis, Jaundice 9 times Possibly Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pancreas.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Morgan, M. D.

19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL Sept 26 1930

20 UNDERTAKER S Lennon Bro — ADDRESS 1127 E Balto St

...c.—1-30—M. & T.—250 2ks.

60863

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/E 60863

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1359 Ward St ST. 21-29 WARD)

2-FULL NAME Elizabeth Shorter

(a) RESIDENCE NO. 1359 Ward St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) 1893

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John Shorter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Shorter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Eliza Shorter

(Address) 1359 Ward St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, to Sept 23, 1930,

that I last saw h.f.l alive on Sept 23, 1930,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mary Stoag, M. D.

Sept 23, 1930 (Address) 729 Eutaw. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 9-26 1930

20 UNDERTAKER Hend Easton

ADDRESS 916 Pa Ave

Fc.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60864

CERTIFICATE OF DEATH.

3 E 60864

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ..... ST., 14-27 WARD)

2-FULL NAME Theodore Davis

(a) RESIDENCE NO. 1511 W. Lexington st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced (HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) May 20, 1912

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	4	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Wilson
(State or country) North Carolina

10 NAME OF FATHER Joseph Davis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Martha McCallum

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant Hospital Records
(Address)

15 Filed 9-26 1930 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to Sept. 25, 1930, that I last saw him alive on Sept. 25, 1930, and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Tenner, M. D.

9-26, 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 9-26 1930

20 UNDERTAKER Sonny Earlam

ADDRESS 916 Ba ave

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60865

CERTIFICATE OF DEATH.

90 E 60865

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO. C ST. 15-54 WARD)

2-FULL NAME Sarah Frist

(a) RESIDENCE NO. 2344 Pennsylvania Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur John

DATE OF BIRTH (month, day, and year) Aug. 15, 1859

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	1	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Co Md.

10 NAME OF FATHER Moses Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md.

12 MAIDEN NAME OF MOTHER Louisa Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co Md.

Informant (Address) Records of Balto. City Hosp.

Filed 9-26 1930. C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-30

17 I HEREBY CERTIFY, That I attended deceased from 6-3-30, 19, to 9-25-30, 19, that I last saw her alive on 9-25-30, 19, and that death occurred, on the date stated above, at 5:10 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

Auricular fibrillation

More than (duration) yrs. 3½ mos da.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) UNKNOWN yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

9-25 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Sept 27 1930

20 UNDERTAKER Chas S Black

ADDRESS 742 W. Baltimore Ave

ec.—1-30—M. & T.—250 Bks.

E 60366

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 60366

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (NO. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Clara Lemberg

(a) RESIDENCE NO. Brooklyn N.Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

If married, widowed, or divorced (HUSBAND of or) WIFE of Samuel

DATE OF BIRTH (month, day, and year) Mar-14-1880

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	6	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.ife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Meyer Wolodarsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed ..... 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-26-1930

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Sept 26, 1930, that I last saw her alive on Sept 26, 1930, and that death occurred, on the date stated above, at 12 50 A m.

The CAUSE OF DEATH* was as follows:

Addisons Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Meo Abramopf, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn N y

DATE OF BURIAL 9/26/30

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 Bway

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60367

REGISTERED NO. E 60367

1-PLACE OF DEATH

City of BALTIMORE: (No. 1950 Perlman Place Ward 16)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L. Dietrich

(a) RESIDENCE NO. 1950 Perlman Place Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 24/1913

7 AGE: Years 17 Months 8 Days 1 If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Operator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Henry Dietrich

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Frederick

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country) Md

14 Informant Frank Dietrich

(Address) 1950 Perlman Place

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1930, to Sept 24, 1930,

that I last saw h.. alive on Sept 24, 1930,

and that death occurred, on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis ?

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. W. Thomas, M. D.

Sept 29, 1930 (Address) 1228 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul com. Ger. Ref. Date of Burial: Sep 29 1930

20 UNDERTAKER: Frank A. Fink ADDRESS 9158 N. Gay St

ec.—1-30—M. & T.—250 Bks.

60868 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60868

CERTIFICATE OF DEATH. 161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 13-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Nechamkin

(a) RESIDENCE NO. Sinai Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 24, 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Samuel S. Nechamkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Ida Mendelsohn

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland.

Informant Jack Lewis

(Address) 1437 E. Baltimore St.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1930, to Sept 26, 1930, that I last saw her alive on Sept 26, 1930, and that death occurred, on the date stated above, at 2 00 G.m.m.

The CAUSE OF DEATH* was as follows:

Hemmorhagic disease of the new born — Premature —

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? clinical

(Signed) Archie Robert Cohen, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 9/26 1930

20 UNDERTAKER Jack Lewis — ADDRESS 437 Balto St.

6 1930 HUDSON JONES, M. D.

c.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

60869 90 E 60869

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO.

2-FULL NAME Louis Miller

(a) RESIDENCE NO. 1812 Dover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Aug. 20, 1856

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	1	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Louisville Ky.

10 NAME OF FATHER Elijah Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Josephine Chivialer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky.

Informant Records of (Address) Balto. City Hosp.

Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24-30

17 I HEREBY CERTIFY, That I attended deceased from 4-16-29, 19, to 9-24-30, 19,

that I last saw him alive on 9-24-30, 19,

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocard. fis. chronic

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

9-25 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 27 1930
UNDERTAKER Harry H. Witzke	ADDRESS 410 Edmondson Ave

HARRISON JONES, M. D.

76 1930

...c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60870 — 100-001 — E. 60870

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N. Arlington Ave ST. 18-16 WARD)

2-FULL NAME Charles Lee

(a) RESIDENCE NO. 206 N. Arlington Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Deborah Lee

DATE OF BIRTH (month, day, and year) March 15, 1878

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	52	6	8 9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Queene Anne Co., Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Margarete Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queene Anne Co.

Informant Margaret Snowden

(Address) 206 N. Arlington Ave

Filed 26 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-23-30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1930, to Sept. 23, 1930, that I last saw h alive on Sept 23, 1930, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchi Pneumonia

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) Tracheobronchitis

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Cal-

(Signed) H. Mateo Williams, M. D.

9-24-1930 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Sept 27th 1930

20 UNDERTAKER A. Jones

ADDRESS 111 E Lfayo

...c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60871

90 E 60871

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 500 N. Pat. Pk. Ave. (St.) 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Smith

(a) RESIDENCE No. 500 N. Pat. Pk. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced (HUSBAND) of (or) WIFE of late Samuel R. Smith

DATE OF BIRTH (month, day, and year) Oct 1/46

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	83	11	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Richard Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Krouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret Derr

(Address) 500 N. Pat. Pk. Ave

15 Filed SEP 26 1930 C. HAROLD JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 19 30 to Sept 24, 19 30

that I last saw him alive on Sept 24, 19 30

and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH was as follows:

Mitral Regurgitation

Pneumonia

(duration) 1 yrs. mos. days

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Philip Hermig M. D.

19 26 Sept 00 (Address) 1000 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL 9/27 1930

20 UNDERTAKER Philip Hermig

ADDRESS 2016 Orleans St

ec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60872 — 59-E 60872

CERTIFICATE OF DEATH.

REGISTERED NO. 159

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2136 (Clifwood Ave) ST., 8-11 (WARD)

2-FULL NAME Baby Boy George

(a) RESIDENCE NO. 2136 Clifwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 9-25-30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Everett H George

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country) Ohio

12 MAIDEN NAME OF MOTHER Agnes Kidd

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Everett H George (Address) 2136 Clifwood Ave

15 Filed 9 26 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/25, 1930, to 9/25, 1930, that I last saw him alive on 9/25 1930 and that death occurred, on the date stated above, at 10 PM. m.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(duration) yrs. mos 2 hr ds.

CONTRIBUTORY (Secondary) premature birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) David Miller, M. D.

9/26, 1930 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 9/26 1930

20 UNDERTAKER Frank A. Ole — ADDRESS 1400 W. Fayette

...c.—1-30—M. & T.—250 Blks

E 60873 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60873

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 2808 Orleans ST., 6-11 WARD)

2-FULL NAME Mary E. Hollins

(a) RESIDENCE NO. 2808 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

If married, widowed, or divorced (or) WIFE of HUSBAND of

DATE OF BIRTH (month, day, and year) Nov 17-1903

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	10	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Men Shirt Mgnf.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto City

10 NAME OF FATHER Louis Hollins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mary Kenan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

Informant Mary Hollins

(Address) 2808 Orleans

C. HAMPSON JONES, M. D. Registrar

Filed 6 1930 ...19... Rec.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 19 to Sept 23, 19 30

that I last saw he alive on Sept 23, 19 30

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Endocarditis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Acid fast (Tubercle) Infection of Lungs

(duration) yrs. 4 mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Kramer M. D.

19 (Address) Med Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mem Cathedral

DATE OF BURIAL Sept 27 19 30

20 UNDERTAKER J. A. Moran

ADDRESS 2000 E. Baltimore

...ec.—1-30—M. & T.—250 Bks

E 60874 E 60874

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Balto. City Hospitals 9-22-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME James Matthews

(a) RESIDENCE NO. 608 China ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of or) WIFE of -

DATE OF BIRTH (month, day, and year) July 4, 1884

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	2	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Wilmington N. C.

10 NAME OF FATHER John Quince

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Ollie Herrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

Informant (Address) Records of Balto. City Hosp.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-30

17 I HEREBY CERTIFY, That I attended deceased from 9-20-30, 19 ... to 9-22-30, 19 ..., that I last saw h... im alive on 9-22-30, 19 ..., and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of central Nervous System

(duration) unknown. yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage into Cerebyum (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassaman i exam

(Signed) Paul Padget, M. D.

9-25, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 26 1930 19

20 UNDERTAKER Commissioner Health

Per Wm. H. WOODA...

ADDRESS

C. HAMPSON GIBSON, M. D.

SEP 26 1930

Registrar

C.—1-30—M. & T.—250 Blks

E 60875

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60875

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 23-33
CITY OF BALTIMORE: (NO. ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grady Schoats

(a) RESIDENCE NO. 1110 Hasselberger Court ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of Eliza Schoats

DATE OF BIRTH (month, day, and year) July 4, 1903

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	2	19	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown

BIRTHPLACE (city or town) Gastonia
(State or country) North Carolina

10 NAME OF FATHER John Schoats

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lizzie Bomat

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Hospital Records
(Address)

15 Filed ....., 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Sept. 23, 1930, that I last saw him alive on Sept. 23, 1930, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) David Jenner, M. D.
9-23 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL
DATE OF BURIAL SEP 25 1930 19

20 UNDERTAKER Miller Heath
Per. Wm. E. WOODALL.
ADDRESS

C.—1-30—M. & T.—250 Bks

E 60876 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60876

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 7-13 WARD)

CITY OF BALTIMORE: (NO. ST.

2-FULL NAME Oscar Bouchard

(a) RESIDENCE NO. 915 N. Washington st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) May 5, 1902

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	4	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Denmark

10 NAME OF FATHER Oscar Bouchard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Loretta Petersen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant Hospital Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 6 1930, 19 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Sept. 23, 1930, that I last saw him alive on Sept. 23, 1930, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Seuner, M. D.

9-23, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 26 1930 19

ADDRESS

20 UNDERTAKER Commissioner Health

Per W. E. [illegible]

c.—1-30—M. & T.—250 Bks.

240948 E 60877

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60877 ✓ 100-00

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME Jean E. Brown

(a) RESIDENCE NO. Wash D C ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced (or) HUSBAND of WIFE of Bertha Blue

DATE OF BIRTH (month, day, and year) Nov 3-1872

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	10	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N Y.

10 NAME OF FATHER Clarence

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Y

12 MAIDEN NAME OF MOTHER Agnes Morretz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Y

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar C. HAMILTON JONES, M.D.

SEP 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, to Sept 25, 1930, that I last saw him alive on Sept 25, 1930, and that death occurred, on the date stated above, at 6.40 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(duration) 20 yrs. + mos. ds.

18 Where was disease contracted if not at place of death? Spring Lake N. J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) C. M. Fisher, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Syracuse N.Y.

DATE OF BURIAL 9/28 1930

UNDERTAKER John D. Mitchell

ADDRESS 1210 Eutaw Place

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60878 — 188-103 — E 60878

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square Hospital St. 8-40 Ward)

2-FULL NAME ADOLPH R. OBERENDER

(a) RESIDENCE NO. 3213 Cliftmont Ave. St., _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced — — —
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 16, 1911

7 AGE	Years	Months	Days	IF LESS (han 1 day hrs. or min.
	19	0	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Oberender

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Germany

12 MAIDEN NAME OF MOTHER Antonette Behn

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Germany

14 Informant Mr. John Oberender (Father)
(Address) 3213 Cliftmont Ave.

15 Filed _____, 19__ _____ Registrar

6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto he was driving overturned & [illegible] with another following him & [illegible]

(a) Fract Skull (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Holland & Gilmore

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Frame, M. D.

9/25. 1930 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery (Oakwood)

DATE OF BURIAL Sept 26 1930

ADDRESS Baltimore & Broadway

20 UNDERTAKER Henry Sander & Sons, Inc.

c. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60879 ✓ 90 E 60879

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 534 Maud Ave. ST. 25-75 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pauline Westinghausen

(a) RESIDENCE NO. 534 Maud Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Westinghausen

DATE OF BIRTH (month, day, and year) Dec. 3, 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Lange

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

Informant John Westinghausen (Son)

(Address) 534 Maud Ave.

Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 25, 1930

that I last saw h[illegible] alive on Sept 23, 1930

and that death occurred, on the date stated above, at [illegible] a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) J. Hayward Lawrence M. D.

9/26 1930 (Address) 1 W Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's 5th Ref. Ch. Cem.

DATE OF BURIAL Sept. 28 1930

20 UNDERTAKER Henry Sanger & Sons - Inc.

ADDRESS Baltimore St & Broadway

c.—1-30—M. & T.—250 Bks

E 60880

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60880

CERTIFICATE OF DEATH.

REGISTERED NO. 23

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ..... ST., 2 WARD)

2-FULL NAME William Vogler

(a) RESIDENCE NO. none ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of --

DATE OF BIRTH (month, day, and year) Dec. 15, 18[illegible]

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
38	10	19 11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work market man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Adam Vogler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Bocht[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Records of Balto. City Hosp.

15 Filed 6-[illegible]-30 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-26-30

17 I HEREBY CERTIFY, That I attended deceased from 8-31-30, 19..., to 9-26-30, 19...,

that I last saw h... alive on 9-26-30, 19...,

and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Senility

Spastic Paraplegia with Contracted Kidney

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

1[illegible] (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's 5th. Ref. Ch. Cem.

DATE OF BURIAL Sept. 29 1930

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS Baltimore St. & Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60881

E 60881

CERTIFICATE OF DEATH

170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 859 Park Ave. St. 11-27 Ward)

2-FULL NAME Walter M. Bird.

(a) RESIDENCE NO. 859 Park Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or WIFE of) Charlotte Bird.

6 DATE OF BIRTH (month, day, and year) July 21, 1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pittsburg, Pa.
(State or country)

PARENTS

10 NAME OF FATHER Michael Bird.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget C. McMahon.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England.

14 Informant Charlotte Bird. (wife)
(Address) 859 Park Ave.

15 Filed ..., 1930 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 24, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound of the Head.
Suicide while mentally deranged.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Kernhardt, M. D.

9/24 1930 (Address) 1017 N. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Nat. Cemetery Va.

DATE OF BURIAL Sept 27 1930

20 UNDERTAKER S. Levinson & Bro

ADDRESS 1127 E Balto st

c.—2-29-28—L. F. S.—500 Bks.

60882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 60882

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 449 Lorraine Ave East WARD

2—FULL NAME Susanna M. Kopp.

(a) RESIDENCE NO. 449 Lorraine Ave East. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis C. Kopp.

ATE OF BIRTH (month, day, and year) June 14, 1870

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	11	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Brooklyn (State or country) New York.

10 NAME OF FATHER Adam Jockel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Nazie K. Bloche

(Address) 449 E. Lorraine Ave

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) Sept 25/30 (day and year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 18 1930, to Sept 25 1930, that I last saw h alive on Sept 25 1930 and that death occurred, on the date stated above, at 4.10 p.m.

The CAUSE OF DEATH* was as follows:

Cortical Regurgitation

Myocardial Insufficiency (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Thompson-Haywood M. D.

9/27 1930 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 9/27 1930

ADDRESS

20 UNDERTAKER Henry H. Mears & Son

805 N. Calvert

Filed 9/27 1930 Rec'd

Registrar

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60883 113 E 60883

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 1222 S. Paca ST. 21-24 (WARD)

2—FULL NAME LeRoy Martin Francis

(a) RESIDENCE NO. 1214 S. Paca ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Dec. 21, 1929

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-	9	4	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Martin R. Francis

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) County, Md.

12 MAIDEN NAME OF MOTHER Frances Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Mr. Martin R. Francis

(Address) 1214 S. Paca St.

Filed C. HAMPSON JONES, M. D. 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept 23rd 1930. to Sept. 25th 1930

that I last saw him alive on Sept. 25th 1930

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

CONTRIBUTORY (Secondary) Enteritis (duration) yrs. mos. 1 ds.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Boulton, M. D.

9/26 1930 (Address) 654 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Sept. 27 1930

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 West Baltimore St.

c.—1-30—M. & T.—250 Bks

E 60884 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60884

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5111 Eastern Ave. ST. 26 WARD) 9-6-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence M. Sullivan.

(a) RESIDENCE NO. 5111 Eastern Ave. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Clarence J. Sullivan

DATE OF BIRTH (month, day, and year) Jan. 20th 1895

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	7	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lancaster Pa.

10 NAME OF FATHER John H. Rettle.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Pa.

12 MAIDEN NAME OF MOTHER Mary E. Graeff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Pa.

14 Informant Clarence J. Sullivan (Husband)

(Address) 5111 Eastern Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24/30

17 I HEREBY CERTIFY, That I attended deceased from Jan — 1930 to Sep. 24- 1930, that I last saw h.. alive on Sep. 24- 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1/2 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 1930

Was there an autopsy? No

What test confirmed diagnosis? Kidney Specimen after Operation

(Signed) Morris J. Schneidman M. D.

19 (Address) 6016 Eastern Ave City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Pa. Millersville Mennonite Cemetery — DATE OF BURIAL Sept. 27 1930

20 UNDERTAKER Lilly & Guiler Inc — ADDRESS 403 S. Wolfe St

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60885

CERTIFICATE OF DEATH

129 E 60885

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hospital

TY OF BALTIMORE: (No. Fayette & Calhoun ST., 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. Michael Geraghty

(a) RESIDENCE NO. 117 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of not married

ATE OF BIRTH (month, day, and year) 1860

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70 yrs.	2	7	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Edward Geraghty

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER M'Quade

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

Informant Francis J. Morrel

(Address) 21 Pearl Ave Lawrence Mass

Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1930, to Sept. 25, 1930, that I last saw h[illegible] alive on Sept. 25, 1930 and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (Arterio sclerotic)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No - Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) M. B. Schreiter, M. D.

19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston, Mass.

DATE OF BURIAL Sept. 27 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St

c—1-30—M. & T.—250 Bks

E 60886

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60886

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 N. Bradford St. 6-LD. WARD)

2-FULL NAME Irene E. Behrens

(a) RESIDENCE NO. 132 N. Bradford St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

If married, widowed, or divorced
HUSBAND of
or) WIFE of —

DATE OF BIRTH (month, day, and year) Oct 18, 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	8	

OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Henry Behrens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elis. Abell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Mrs. Henry Behrens

(Address) 132 N. Bradford St.

Filed 9-26-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1930, to Sept 26, 1930, that I last saw h[illegible] alive on Sept 26, 1930, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Toxemia)

(duration) hrs. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 156 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Sept 27, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3008 E. Balto St

4.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 60887

E 60887 REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. 40 E. Cross St ST. 74-22 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Attalt

(a) RESIDENCE NO. 40 E. Cross St. ST.. WARD
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred 56 yrs. 8 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon Attalt

DATE OF BIRTH (month, day, and year) Jan 24-1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	8	2	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary A. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Solomon Attalt
(Address) 40 E Cross St

Filed 9 26 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1930, to Sept 25, 1930, that I last saw h[illegible] alive on Sept 25, 1930 9:30 a.m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma Uteris
Metastasis to Lumbar Spine

CONTRIBUTORY (Secondary) Pulmonary Embolism (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of Nov. 1928

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. J. a Stevens, M. D.

9-26, 1930 (Address) 2878 Holly Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetary DATE OF BURIAL 9/29/1930

20 UNDERTAKER Eger Cook ADDRESS 1217 St Paul St

c.—1-30—M. & T.—250 Bks.

E 60888

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60888

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Sinai Hospital ST. 1-3 WARD)

2-FULL NAME Marion Tutin (Tuczynski)

(a) RESIDENCE NO. 2112 Cambridge ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) July 29 1930

AGE	Years	Months	Days 26	If LESS than 1 day, ... hrs. or ... min.
		1	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Mike Tutin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Wieczorek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Mrs Michael Tuczynski

(Address) 2112 Cambridge

Filed ... Mar ... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Sept. 25, 1930, that I last saw him alive on Sept. 25, 1930, and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis (Under 2 yrs.)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (Type Undet)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? In country. Camden Delaware

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Milton B Kirsh, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: Sept 26 1930

20 UNDERTAKER — ADDRESS: John R Webey 401 Chestnut St

E 60889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 60889

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 717 W. Cross St. ST., 21-24 WARD)

2-FULL NAME Mary Deer Bartel

(a) RESIDENCE NO. 717 W. Cross St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of Peter D. Bartel

DATE OF BIRTH (month, day, and year) Sept. 11

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	0	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Leonard Deer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Hennegan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Peter D. Bartel
(Address) 717 W. Cross St.

15 Filed 9 26 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18th. 1930 to Sept. 24th. 1930

that I last saw her alive on Sept. 24th. 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Ella O'Conclain, M. D.

9/25 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 9/27 1930

UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light St.

c.—1-30—M. & T.—250 Blks

E 60890 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60890

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST. 15-41 WARD)

2-FULL NAME Margaret Green

(a) RESIDENCE NO. 1424 N. Parrish st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 12, 1910

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	4	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mollie ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

Informant Hospital Records
(Address)

Filed 19 C. HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1930, to Sept. 24, 1930.

that I last saw her alive on Sept. 24, 1930.

and that death occurred, on the date stated above, at 7.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) David Penner, M. D.

9-25, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Sept 27, 1930

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Presstman St

...c.—1-30—M. & T.—250 Bks.

E 60891

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60891

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4012 Roland Ave ST., 13 WARD

2-FULL NAME Mary K. Hamilton

(a) RESIDENCE NO. 4012 Roland Ave ST., 13 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced
HUSBAND of
or) WIFE of William L. Hamilton

DATE OF BIRTH (month, day, and year) Jan. 30-1837

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	93	7	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

10 NAME OF FATHER Samuel Abbleby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lydia A. Dillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mrs. William T. Brooks
(Address) 4012 Roland Ave.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930 to Sept 26, 1930 that I last saw h[illegible] alive on Sept 26, 1930 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
Myocarditis

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. F. C. Bryden M. D.

9/29/30 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) DATE OF BURIAL Sept. 29 1930

20 UNDERTAKER Horace E. Burgee ADDRESS 463 Falls Road

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60892

CERTIFICATE OF DEATH

90 E 60892

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE. (No.) 1224 Argyle ST., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan Badger

(a) RESIDENCE NO. 1224 Argyle ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C.	M

If married, widowed, or divorced
HUSBAND of
(or) WIFE of John W. Badger

DATE OF BIRTH (month, day, and year) Unknown 1880

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Miss

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant John W. Badger

(Address) 1224 Argyle

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26/30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 19 30 to Sept 26 19 30

that I last saw h alive on Sept 26 19 30

and that death occurred, on the date stated above, at 8:20 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

(duration) yrs. 6 mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. H. Fletcher M. D.

9/26, 19 30 (Address) 1 W Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn

DATE OF BURIAL 9-28-1930

20 UNDERTAKER Sam'l M. Chase Son

ADDRESS 1401 Madison

c.—1-30—M. & T.—250 Bks

E 60893 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60893

44

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 12-19 (WARD)

2-FULL NAME James O Connell

(a) RESIDENCE NO. 1700 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Anna Fearns

DATE OF BIRTH (month, day, and year) 6-14-62

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Formerly Machinists helper

(b) General nature of Industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Peter O'Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-30

17 I HEREBY CERTIFY, That I attended deceased from 8-30, 1930, to 9-25, 1930, that I last saw him alive on 9-25, 1930, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General metastases.

(duration) 3 (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none -

Did an operation precede death? Yes Date of Jejunostomy 9-12-30

Was there an autopsy? No

What test confirmed diagnosis Clinical & operative

(Signed) J. Leyko, M. D.

9/25, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem

UNDERTAKER J. F. Tahensteas

DATE OF BURIAL 9/29/30

ADDRESS 1318 Eutaw St

C. HAMPSON JONES, M. D.

—M. & T.—100 B—50L

E 60894

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60894

CERTIFICATE OF DEATH

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1755 E. Preston ST. 8-13 WARD)

2-FULL NAME James F. Driscoll

(a) RESIDENCE NO 1755 E. Preston ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Driscoll

DATE OF BIRTH (month, day, and year) Mar 31/1872

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	5	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hoisting Enguneer

(b) General nature of Industry, business, or establishment in which employed (or employer) Coal Loding

(c) Name of employer Baker, Whitely Co

BIRTHPLACE (city or town) (State or country) Balto., Md

10 NAME OF FATHER James Driscoll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Rich. F. Weinkam

(Address) Dorsey Ave, Essex, Md.

Filed ..... 192 ..... Registrar

C. HAMPSON JONES, M.

9/27/1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 26/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) ..... Coroner, M. D.

9/27/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer cem

DATE OF BURIAL Sept 29 1930

20 UNDERTAKER Wendell J Dippel

ADDRESS 3005 Eden st

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60895 113 E 60895

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1116 Battery Ave ST. 24-33 WARD)

2—FULL NAME Emerson Thomas Myers, Jr.

(a) RESIDENCE NO. 1116 Battery Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 2nd 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Emerson Thos Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Magdalen Straub

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

Informant Emerson Thos Myers

(Address) 1116 Battery Ave.

Filed 9-27 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from 9.19.30, 19, to 9.26.30, 19, that I last saw him alive on 9.26.30, 19, and that death occurred, on the date stated above, at 6.35 P m. Eastern Standard Time

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) J. Edward Norris, M. D.

9-27 1930 (Address) 107 East west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A A Co. DATE OF BURIAL 9-28 1930

20 UNDERTAKER E & B Harder ADDRESS 115 E Mt St

c.—1-30—M. & T.—250 Bks

E 60896

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60896

57

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals 7-4 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Albert Schnoor

(a) RESIDENCE NO. 230 S. Ann ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

DATE OF BIRTH (month, day, and year) Oct. 9, 1871

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58 59	11	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work cake packer

(b) General nature of industry, business, or establishment in which employed (or employer) 56

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Robert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Susan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records of Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

C. HERBERT JONES, M. D.

77030

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-30

17 I HEREBY CERTIFY, That I attended deceased from 9-17-30, 19 ..... to 9-25-30, 19 .....

that I last saw h. im alive on 9-25-30, 19 .....

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Diabetic gangrene, rt. foot (1 month)

(duration) 4 yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Infarct of lung.

(duration) ..... yrs. ..... mos. 2 da.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? yes Date of 9-24-30

Was there an autopsy? no

What test confirmed diagnosis? Exam: Laboratory.

(Signed) Paul Padget M. D.

9-26 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Sept 30 1930

20 UNDERTAKER M. W. & Suppel ADDRESS 321 Ann St

—M. & T.—100 B—50L

60897

HEALTH DEPARTMENT—CITY OF BALTIMORE

60897

CERTIFICATE OF DEATH

REGISTERED NO. 4182

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Harbor Hospital ST., Lancaster & Caroline WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Labrador

(a) RESIDENCE No. 256 Aliceanna ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) Sept 1 1923

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
7		24	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Spain

10 NAME OF FATHER John Labrador

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Esperanza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

Informant John Labrador
(Address) 256 Aliceanna St

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acc Drowning while playing

(duration) 1 yrs. mos — ds.

CONTRIBUTORY (Secondary) Not stated (duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? Lan & Caroline

Did an operation precede death? — Date of —

What was autopsy? —

What was confirmed diagnosis? History

(Signed) H. C. Wades Coroner, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 27 1930

20 UNDERTAKER M. W. E. Dippel Inc ADDRESS 311 Aliceanna

c.—1-30—M. & T.—250 Bks.

E 60898 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60898

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2622 Bonne ST., 4-46 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wynn

(a) RESIDENCE NO. 2622 Bonne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Widower

If married, widowed, or divorced HUSBAND of or) WIFE of: Martha Wynn

DATE OF BIRTH (month, day, and year): June 1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

BIRTHPLACE (city or town) (State or country): VA

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Lillie Wynn

(Address) 2622 Bonne st

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1930 to Sept 25, 1930, that I last saw him alive on Sept 25, 1930, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Evidently some malignant trouble in abdomen - Exceedingly Emaciated and passing coagulated blood from bowels

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Paraplegia

(duration) 2 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D.

Sept 26, 1930 (Address) 5104 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lenty — DATE OF BURIAL: Sept 27 1930

20 UNDERTAKER: Mrs. P. A. Elliott — ADDRESS: 1725 Argyle

1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60899

90 E 60899

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1145 May St. St. 5-8 Ward)

2-FULL NAME Abraham Taylor.(C)

(a) RESIDENCE NO. 1145 May St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. ---mos.--- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Widower.

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of XXXXXXXXX WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Taylor.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Stewart.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Bessie Stewart.(C) cousin.
(Address) 415 Mott St.

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 25, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Eisenhard, M. D.

9/29/1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem.	9-27 1930
20 UNDERTAKER	ADDRESS
Byron Wright	1218 N. Eden St.

Spec.—1-10-21—M&T—1500 Bks.

E 60900

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60900

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St Agnes Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Adam Reese

(a) RESIDENCE NO. Lees Cross Roads - Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE: Years 72; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lees Cross Rds Pa

PARENTS

10 NAME OF FATHER: Adam
11 BIRTHPLACE OF FATHER (city or town) (State or country): Lee Cross Rds Pa
12 MAIDEN NAME OF MOTHER: Walters
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Clearsburg Pa

14 Informant: Hospital
(Address)

15 Filed 7 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-25, 1930, to 9-27, 1930,
that I last saw h[illegible] alive on 9-27, 1930,
and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
1- Primary - Carcinoma of Rectum - C metastases
2- Secondary Cachexia -
(duration) 3 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Cachexia -
(duration) 0 yrs. 8 mos. 0 ds.

18 Where was disease contracted if not at place of death? Lees Crossroads - Pennsylvania
Did an operation precede death? No Date of 9/2/30
Was there an autopsy? no -
What test confirmed diagnosis?

(Signed) L. Clarence Cohen M. D.
19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shippensburg Pa
20 UNDERTAKER: Robert Brooks

DATE OF BURIAL: 9/29 1930
ADDRESS: Chambersburg Pa

ec.—8-16-29—L. F. S.—100 Bks.

E 60901

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60901

CERTIFICATE OF DEATH

X 57

REGISTERED NO. 12-50

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. St. Paul & 23rd. Sts. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wade Hampton Fisher

(a) RESIDENCE NO. Buckhannon W.Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Ella V. Nwwlon

DATE OF BIRTH (month, day, and year) May.14.1864

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	4	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Atty. at law

(b) General nature of industry, business, or establishment in which employed (or employer) 0+2

(c) Name of employer

BIRTHPLACE (city or town) (State or country) West Va.

10 NAME OF FATHER John S.Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Harriet A Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Ella V.Fisher

(Address) Buckhannon W.VA.

Filed 12 8 1930 19 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27. 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 19 30, to Sept 27 19 30

that I last saw h[illegible] alive on Sept. 24- 19 30

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Haemachromatosis & Cirrhosis of the liver.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Decompensated heart. unknown. Diabetes. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of no.

Was there an autopsy? partial.

What test confirmed diagnosis? Many clinical tests.

(Signed) Nathaniel M Beck M. D.

, 19 (Address) 1002. 23rd St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Buckhannon W.Va. DATE OF BURIAL Sept.29, 30

20 UNDERTAKER John O.Mitchell & Sons ADDRESS 1900 Eutaw Place

Cor.—10-10-29—A Co.—100 Bks.

E 60902

HEALTH DEPARTMENT—CITY OF BALTIMORE

Goldsmith

CERTIFICATE OF DEATH

E 60902

REGISTERED NO. 57

1-PLACE OF DEATH

City of Baltimore: (No. 413 South Caroline St., St., 34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Golfsmith

(a) RESIDENCE NO. 413 S. Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Harry

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Aaron -------

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Harry Goldsmith (Son)
(Address) 413 S. Caroline St.,

15 Filed ---, 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy?
What test confirmed diagnosis? Clinical

(Signed) H. C. Stadig M. D.

(Address) 1436 Bway 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rd Cemet. DATE OF BURIAL 9/30/30 19

20 UNDERTAKER Jack Lurie ADDRESS 1429 Balto

9 30 1930 Regr. Registrar

Spec.—1-10-21—M&T—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60903

REGISTERED NO. X 144

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. University Hospital WARD) 30

2-FULL NAME Violetta Murdock

(a) RESIDENCE NO. Jacobsville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE B

5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1899

7 AGE Years 31 Months — Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hallie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mr Murdock Jacobsville Md

15 Filed Sept 28, 1930 RK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930, to Sept 27, 1930, that I last saw h[illegible] alive on Sept 27, 1930, 6.30 A m. and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Postpartum hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History & Phys Ex

(Signed) G. J. Scrogs, Jr. M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mag's Chy

DATE OF BURIAL Sept 29, 30

20 UNDERTAKER John H Trader ADDRESS 1027 Druid Hill

SEP 28 1930

c.—2-29-28—L. F. S.—500 Bks.

E 60904

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

E 60904

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 6602 Marne Ave ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME TEOFELA CYBULSKI,

(a) RESIDENCE NO. 6602 Marne Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Cybulski,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Grodence,

(State or country) German Poland

10 NAME OF FATHER August Ticholski,

11 BIRTHPLACE OF FATHER (city or town) Grodence

(State or country) German Poland,

12 MAIDEN NAME OF MOTHER Julia*****

13 BIRTHPLACE OF MOTHER (city or town) Grodence

(State or country) German Poland,

Informant Mrs. Teresa Olis, (Daugther)

(Address) 508 So. Glover Street

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1930, to Sept 25, 1930, that I last saw h[er] alive on Sept 25, 1930 and that death occurred, on the date stated above, at 4.00 P- m. S.T.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) as Peritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? while at work

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Pernitious Anemia

(Signed) H. Leonards Jr, M. D.

26.9.1930 (Address) 1511 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus.

DATE OF BURIAL Sept. 29 1930.

ADDRESS 2215 Pulaski

20 UNDERTAKER W. F. Sadowski.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60905 E 60905

CERTIFICATE OF DEATH

129 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No. 520 N Luzerne Ave St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter B. Thompson

(a) RESIDENCE NO. 520 N Luzerne Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida M. Thompson

6 DATE OF BIRTH (month, day, and year): July 12 1859

7 AGE: Years 71 Months 3 Days 13

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bank Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): Banking Business

(c) Name of employer: Mercantile Trust & Dep. Co

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Wm Thompson

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Scott

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant: Est of Bowers

(Address) 5309 Rueckert Ave.

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 10 1927 to Sept 25 1930

that I last saw him alive on Sept 25 1930

and that death occurred, on the date stated above, at 7.14 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis & Chronic Nephritis

(duration) 3 yrs. 2 mos. 7 ds.

18 Where was disease contracted at Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jesse Hoff M. D.

9/26 1930 (Address) 2616 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

Date of Burial 9/29 1930

30 UNDERTAKER Philip Herzig

ADDRESS 2016 Orleans St

C.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60906 — 27-5-75-001 — E 60906

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4831 Keswick Road ST., 27-5-75 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Buck

(a) RESIDENCE NO. 4831 Keswick Road ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 27, 1858,

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Alfred Buck

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia I. Groverman

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Henrietta W. G. Buck (Address) 4831 Keswick Road

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9.27.30.

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929 to Sept 26, 1930, that I last saw h[illegible] alive on Sept 26, 1930, and that death occurred, on the date stated above, at 2.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia, Right

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emma C. Clarke, M. D.

(Address) La Fetra apts Charles & Read

9/27, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Sept. 29, 1930,

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North ave

c.—1-30—M. & T.—250 Bks.

E 60907

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60907

CERTIFICATE OF DEATH.

135

REGISTERED NO.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) Balto. City Hospitals (ST.) J-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Herman

(a) RESIDENCE NO. 208 S. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

If married, widowed, or divorced HUSBAND of or) WIFE of Mary Smith

DATE OF BIRTH (month, day, and year) Dec 26 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	9	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Nicholas Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry F. J. Disney (Address) 401 N. Fayette Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-30

17 I HEREBY CERTIFY, That I attended deceased from 9-9, 19 30 to 9-27, 19 30

that I last saw h~~im~~ alive on 9-27, 19 30

and that death occurred, on the date stated above, at 7 20 p m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate Gland - Acute Urinary Retention

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-23-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Luther E. Leitch, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL Sept. 30, 1930

20 UNDERTAKER Palm & Ritz

ADDRESS 408 S. Highland Ave

c.—1-30—M. & T.—250 Bks

E 60908 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60908

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 13-57

ITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Wilt

(a) RESIDENCE NO. 3534 Buena Vista ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John Wilt

DATE OF BIRTH (month, day, and year) Mch. 7, 1887 ?

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43 ?	6	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 031

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER William Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Victoria Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

PARENTS

14 Informant Hospital Records

(Address)

15 Filed 9-29 1930 E. K. Jones, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1930, to Sept. 26, 1930,

that I last saw her alive on Sept. 26, 1930,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Jenner, M. D.

9-27 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Sept 1930

20 UNDERTAKER Ebenezer Lee Son

ADDRESS

M. & T.—100 B—50L

E 60909

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60969

CERTIFICATE OF DEATH

113

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 24-33 WARD)

2-FULL NAME June [illegible] M. Durham

(a) RESIDENCE NO 1207 Battery Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

If married, widowed, or divorced
(husband) of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 13/1930

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	14	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER James Durham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mildred Riley

13 BIRTHPLACE OF MOTHER (City or town) (State or country)

Informant Mildred Durham

(Address) 1207 Battery Ave

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Marasmus - Gastro-intestinal indigestion.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical history

(Signed) [illegible], M. D. Coroner

9/27/30 (Address) 50 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

DATE OF BURIAL Oct 2 1930

20 UNDERTAKER Chenowith & Son

ADDRESS 365 Chestnut Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60910

185 E 60910

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH 2605 Rosewood Ave

City of Baltimore: (No. ~~1010 W. Pratt~~ St., 15-56 Ward)

2-FULL NAME Primrose Kennedy

(a) RESIDENCE NO. 2605 Rosewood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Fanny Kennedy

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Mrs. Primrose Kennedy
(Address) 2605 Rosewood Ave

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-28- 1930

17 "I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

THE CAUSE OF DEATH was as follows:
Fracture of Skull
Skull Crushed in motor accident

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

9/29 1930 (Address) 3692 W Lord Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 9-29- 1930

20 UNDERTAKER

ADDRESS

c.—1-30—M. & T.—250 Bks.

E 60911 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 60911

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. Balto City Hospitals ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis K Kline

(a) RESIDENCE NO. 1116 McKean Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Gertrude Kline

DATE OF BIRTH (month, day, and year) July 5th 1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	2	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 140

(c) Name of employer Balto. City

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Wm K Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Gertrude Kline

(Address) 1116 McKean Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-27, 19 30., to 9-26, 19 30, that I last saw h.im alive on 9-26, 19 30 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Penis with Regional Metastases

(duration) yrs. 6 mos 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 1 yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 5-10-30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Luther E Kline, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 9/30 1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60912

CERTIFICATE OF DEATH.

129 ✓

E 60912

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1228 Hull St., 24-35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Carden

(a) Residence No. 1228 Hull St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6-DATE OF BIRTH (month, day and year): NOV. 23. 1853.

7-AGE: 76 yrs. 10 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): House wife

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Thos Mc Hale

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Ellen Ford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-Informant: Mrs James Clarke

(Address): 1228 Hull St

15-Filed: SEP 29 1930 192 Registrar.

C. HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 25 1930

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1930 to Sept. 25 1930

that I last saw her alive on Sept. 25 1930

and that death occurred, on the date stated above, at 3P. m.

The CAUSE OF DEATH* was as follows:

Mens Sclerosis Hypertension

Chronic Interstitial Nephritis

Uraemia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uranalysis & Symptoms

(Signed) Thos Fa Slevin, M. D.

11/27, 1930 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL, Sept 29 1930.

20-UNDERTAKER: Margaret D. Flynn

ADDRESS 1422 Light St

ec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60913 — 9~E 60913

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 418 Ann ST. 2-4 WARD)

2-FULL NAME Ella R. Jackson

(a) RESIDENCE NO. 418 Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 4 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER W M Jackson

11 BIRTHPLACE OF FATHER (City or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia Watson

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Baltimore Md

14 Informant Julia Jackson (Address) 418 Ann St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 27, 1930, that I last saw h[illegible] alive on Sept 27, 1930, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pertussis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no Physical

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL Sept 29 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

ec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60914 Ht E 60914

CERTIFICATE OF DEATH.

REGISTERED NO. 28-66

1-PLACE OF DEATH
CITY OF BALTIMORE (NO. 1207 Walnut Ave ST. 28 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Margaret Wacker

(a) RESIDENCE NO. 1207 Walnut Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

If married, widowed, or divorced
HUSBAND of (or) WIFE of Herman Wacker

DATE OF BIRTH (month, day, and year) Dec. 1, 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	9	25	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS
10 NAME OF FATHER Charles Niemeyer
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER Christina Runkel
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Charles C. Wacker
(Address) 1207 Walnut Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16th, 1930, to Sept 26th, 1930,
that I last saw h er alive on Sept 26th, 1930
and that death occurred, on the date stated above, at 11.05 P m days.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 8 mos 10 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism & Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical symptoms

(Signed) J. E. Poulton, M. D.
9/27 1930 (Address) 3909 Gamson Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.
DATE OF BURIAL Sept 29 30

20 UNDERTAKER Wm J Hickey Sons
ADDRESS North & Pa

rc.—1-30—M. & T.—250 Bks

E 60915 HEALTH DEPARTMENT—CITY OF BALTIMORE 37-002 37 E 60915

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 11-15 ST., WARD)

2-FULL NAME John Edgar Barry

(a) RESIDENCE NO. 411 E. Preston St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Jan. 18, 1892

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38		8	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John R. Barry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Williamsport Maryland

12 MAIDEN NAME OF MOTHER Mary D. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Miss M. Agnes Barry (Address) 411 E Preston St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/26/30.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1930, to Sept 26, 1930, that I last saw h alive on Sept. 26, 1930, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

1 Generalized tuberculosis.

(duration) 32 yrs. — mos. — ds. (?)

CONTRIBUTORY (Secondary) Generalized toxemia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Richard [illegible] M. D.

9/27, 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Oct 1 1930

20 UNDERTAKER J. M. J. Dickson & Jones

ADDRESS Baltimore

JACOB C. HAUPT JONES, M. D.

Dec.—8-16-29—L. F. S.—100 Bks.

60916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 60916

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Reservoir ST. 13-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Jennings Silkman

(a) RESIDENCE NO. 605 Reservoir ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H. Silkman

DATE OF BIRTH (month, day, and year) Nov 17-1859.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	10	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Law Department

(c) Name of employer B & O. Railroad.

BIRTHPLACE (city or town) (State or country) Scranton Pa.

10 NAME OF FATHER Aaron Burr Silkman

11 BIRTHPLACE OF FATHER (city or town) Scranton (State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Striker

13 BIRTHPLACE OF MOTHER (city or town) Shullsburg (State or country) Wis.

14 Informant Edwin F. Silkman

(Address) 605 Reservoir St.

15 Filed 9 1930 19 C. P. JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-26-1930.

17 I HEREBY CERTIFY, That I attended deceased from September 19, 1930, to September 26, 1930, that I last saw him alive on September 26—, 1930, and that death occurred, on the date stated above, at 12:14 P. m.

The CAUSE OF DEATH* was as follows:

Radium Therapy.

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Carcinoma - throat and neck.

(duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes. Date of Dec 1924.

Was there an autopsy? no

What test confirmed diagnosis? physical signs & microscope

(Signed) Chester Riland, M. D.

9-26. 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Sept 29 1930

20 UNDERTAKER Wm. J. Tickner & Sons

ADDRESS N. Fulton Ave.

Dec.—1-30—M. & T.—250 Bks

E 60917

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60917

CERTIFICATE OF DEATH.

54

1-PLACE OF DEATH Baltimore City Hospitals ST. 17-24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Elkton McDaniel

(a) RESIDENCE NO. 582 St. Mary's St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of -

DATE OF BIRTH (month, day, and year) Mar. 22, 1893

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	6	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Blackstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-30

17 I HEREBY CERTIFY, That I attended deceased from 9-16-30, 19..., to 9-25-30, 19..., that I last saw him alive on 9-25-30, 19..., and that death occurred, on the date stated above, at 12:05 A. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Exam. autopsy

(Signed) Paul Padget, M. D.

9-27 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Dawkins Care

DATE OF BURIAL 9. 29 1930

20 UNDERTAKER Dunn Eaton

ADDRESS 9/6 Oa ave.

SEP 29 1930 HARRY JONES, M.

c.—1-30—M. & T.—250 Bks

E 60918 HEALTH DEPARTMENT—CITY OF BALTIMORE É 60918

CERTIFICATE OF DEATH.

+113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 430 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley Cumberland

(a) RESIDENCE NO. Ellicott city ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) March 19 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md.

10 NAME OF FATHER Harry Cumberland.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ellicott City Md

12 MAIDEN NAME OF MOTHER Virginia Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ellicott City Md

14 Informant Harry Cumberland
(Address) Ellicott City Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, to Sept 29, 1930,

that I last saw h.e alive on Sept 29, 1930,

and that death occurred, on the date stated above, at 4 50 a m.

The CAUSE OF DEATH* was as follows:

Toxic enteritis

(duration) ..... yrs. ..... mos 2 days.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm M Faw, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ellicott City Md.

DATE OF BURIAL 9-30 1930

20 UNDERTAKER D. O'Day Embalming Co

ADDRESS Ellicott City Md

—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60919

161-001

E 60919

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N. Castle ST., 7-9 WARD)

2-FULL NAME Janet Lee Albert

(a) RESIDENCE NO 503 N. Castle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 15/30

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			12	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER John C. Albert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Helen R. Horstsneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

Informant John C. Albert

(Address) 503 N. Castle St., Baltimore, Md.

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) ..... Coroner, M. D.

19 ..... (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Sept 29/30 19

ADDRESS Edmondson Ave

20 UNDERTAKER Philip Davis

ADDRESS 2316 Eliana St.

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 60920

E 60920

CERTIFICATE OF DEATH

REGISTERED NO. 16-68

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.) Maryland General Hospital

ITY OF BALTIMORE: (No. Madison & Linden ST., WARD)

2—FULL NAME John Peter Meyers, John P. Meyers

(a) RESIDENCE NO. 1117 N Bentalou ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella Meyers

DATE OF BIRTH (month, day, and year) May 4, 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or.. min.
	71	4	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Straw Hat Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. D. Smith Company

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Charles F Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Barbara Hirst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miss Helen P. Meyers Hospital Records

(Address) 1117 N. Bentalou St.

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1930, to Sept 28, 1930, that I last saw him alive on Sept. 27, 1930, and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Abscess Hypertrophy of Prostate

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/6/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert V. Remsnitz, M. D.

9/28, 1930 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept. 30 1930

20 UNDERTAKER Joseph Cook

ADDRESS 1003 West Baltimore St.

Filed Sept 29 1930 Registrar

ec.—2-29-28—L. F. S.—500 Bks.

E 60921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓ E 60921

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 2819 Windsor Ave. ST. 15-60 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Philip Marcus Smith

(a) RESIDENCE NO. 2819 Windsor Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Euphemia Smith

DATE OF BIRTH (month, day, and year) May 14th 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	3	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Princess Anne Co. Maryland

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Princess Anne Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Ballard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Princess Anne Maryland

14 Informant S. Philip Smith
(Address) Cape Charles Va.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 28th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 . 19 30 . to Sept 27 . 19 30 .

that I last saw h alive on Sept 27 . 19 30

and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) - Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Coroner

(Signed) Edw Neuhaus, M. D.

Sept. 28 1930 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Sept 30 1930

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St.

C. HAMILTON JONES, M. D.

Sec.—1-30—M. & T.—250 Blks

Hastler

E 60922

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60922

90

CERTIFICATE OF DEATH.

REGISTERED NO. 76-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 S. Eaton ST., 26 WARD)

2-FULL NAME William H. Hastler.

(a) RESIDENCE NO. 612 S. Eaton ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

If married, widowed, or divorced HUSBAND of (or) WIFE of the late Mary Hastler

DATE OF BIRTH (month, day, and year) June 27 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired City Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Hastler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sophie Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Carrie Krueger (Niece)

(Address) 612 S. Eaton St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Sept 26, 1930, that I last saw him alive on Sept 26, 1930, and that death occurred, on the date stated above, at 7 15 a.m.

The CAUSE OF DEATH* was as follows:

Arteria Selerosis Cardio Vascular Vasinum & Hypertension

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H H Kupelmeier M. D.

9/27 1930 (Address) 2931 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL Sept 29th 1930

20 UNDERTAKER Lilly & Julen Inc.

ADDRESS 403 S. Wolfe St

C. MAURICE JONES, M. D.

Dec.—8-16-29—L. F. S.—100 Bks.

60923

HEALTH DEPARTMENT—CITY OF BALTIMORE

45V E 60923

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Rochambeau Aparts ST. 11-25 WARD)

Charles & Franklin Sts.

2—FULL NAME Sarah Elizabeth Pritchard

(a) RESIDENCE NO. Charles & Franklin Sts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Pritchard Rear Admiral Arthur J.

DATE OF BIRTH (month, day, and year) Oct. 21.1841

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	11	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Dorchester Co.

(State or country) Md.

10 NAME OF FATHER Samuel Harrington

11 BIRTHPLACE OF FATHER (city or town) Dorchester

(State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Frazier

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dorchester Co. Md.

Informant Calvin Harrington

(Address) Cambridge Md.

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28.30

17 I HEREBY CERTIFY, That I attended deceased from January 1st, 1930, to September 28th, 1930, that I last saw h[illegible] alive on Sept. 27, 1930 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of duodenum.

(duration) — yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar D. Perkins M. D.

Sept 28, 1930 (Address) Rochambeau. 1 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Madison, Dorchester Co. Md.

DATE OF BURIAL Sept 30.30 19

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Eutaw Place

Registered Sept 29 1930 CLARENCE JONES, M. D.

c.—1-30—M. & T.—250 Bks

E 60924 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60924

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Kirkleigh Villa ST. 27-5 WARD)

2-FULL NAME Jeannie V. S. Dailey

(a) RESIDENCE NO. Kirkleigh Villa ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of C Woods Dailey

DATE OF BIRTH (month, day, and year) Mar. 2 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	6	26.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thos. Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Mary M. Gregory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Mrs. E. Grandlee

(Address) 1036 E 36th St

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 1930 to Sept. 28 1930

that I last saw h[illegible] alive on Sept. 26 1930

and that death occurred, on the date stated above, at 12 M. night

The CAUSE OF DEATH* was as follows:

Chronic endocarditis with sudden heart failure

(duration) yrs. 9 mos 28 ds.

CONTRIBUTORY (Secondary) Senile arteriosclerosis

(duration) 1+ yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) M. Isham Porter, M. D.

9/29 1930 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkins W. Va.

DATE OF BURIAL Sept 29 1930

ADDRESS

20 UNDERTAKER Rule Undefined Greenmount Ave

C. HAMILTON JONES, M. D.

SEP 29 1930

c.—1-30—M. & T.—250 Bks

E 60925

E 60925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-601

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 211 Rock. ST. 18-76 WARD)

2-FULL NAME ~~Baby Fields~~ Eleanor Jeanette Fields

(a) RESIDENCE NO. 211 Rock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 9/27/30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1 hrs. 20 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Robert Fields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mildred Wooden

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

PARENTS

14 Informant Mildred Fields (Mother)

(Address) 211 Rock St.

15 Filed 9-29 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27/30

17 I HEREBY CERTIFY, That I attended deceased from 9/27, 1930, to 9/27, 1930, that I last saw h[illegible] alive on 9/27, 1930, and that death occurred, on the date stated above, at 5 50 P m.

The CAUSE OF DEATH* was as follows:

Premiturity

32 weeks

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) unknown.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopay? no

What test confirmed diagnosis? History & Physical Examinati

(Signed) R. C. Hudson, M. D.

19 (Address) University of Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Sept 29, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 3221 Schroeder St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60926

CERTIFICATE OF DEATH.

128 E 60926

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1022 Edmonson ave (St.) 16-26 (Ward)

2-FULL NAME John Fletcher

(a) RESIDENCE NO. 1022 Edmonson ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Elyabeth Fletcher

7 DATE OF BIRTH (month, day, and year): April 20. 1886

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: John H Fletcher

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: Elyabeth Fletcher

(Address) 1022 Edmonson ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-26-'30 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21st. 19 30. to Sept. 26th. 19 30.

that I last saw him alive on Sept. 26th. 19 30

and that death occurred, on the date stated above, at 8.35 a.m.

The CAUSE OF DEATH* was as follows:

~~Acute Parenchymatous~~

Acct. Parenchymatious Nephriti

Of unkno n origin

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin st.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Zion — DATE OF BURIAL: Sept 29 1930

20 UNDERTAKER: Joseph A Lively — ADDRESS: 409 N Howard st

WILLIAMSON JONES, M. D.

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60927

CERTIFICATE OF DEATH

90 E 60927

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 318 E 23rd ST. 12-5D WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mattie J. Bowers

(a) RESIDENCE NO. 318 E 23rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1870

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Edgefield S.C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs Simpson

(Address) 318 E 23rd

Filed Oct. 1, 1930 C. T. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29, 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1930, to Sept 29, 1930.

that I last saw her alive on Sept 26, 1930

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Brittal Pneumonia or Partial amputation of Heart

(duration) 2 yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) Heart trouble

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Typical Course

(Signed) T. Dale, M. D.

, 19 (Address) 2662 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cooley S.C.	Oct 1 1930
20 UNDERTAKER Samuel Kinsley	ADDRESS 1713 Eutaw

—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60928 | 179 E 60928

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) Franklin Square Hospital ST. 1427 WARD

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman Smith

(a) RESIDENCE NO. 503 N. Paca St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 7-1929

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		21	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron
(b) General nature of industry, business, or establishment in which employed (or employer) 00
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Walter Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lena Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs Catherine Smith

(Address) 503 N. Paca St.

Filed ....., 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns, at home of Immune

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. H. Brooks, M. D. Coroner

Sept 28 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 30 1930

20 UNDERTAKER Samuel Feinberg

ADDRESS Sept 30 1930

C.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60929

CERTIFICATE OF DEATH.

57 ✓ E 60929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mondawmin Terrace Est 15-58 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Montague Brown

(a) RESIDENCE NO. Mondawmin Terrace Est ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Alex. Brown

DATE OF BIRTH (month, day, and year) Feb 16 1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	7	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ "

(c) Name of employer ✓ "

BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Charles P. Montague

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliza Denison

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

Informant Baltimore Trust Co

(Address) Roland Park - Baltimore

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 1925, to Sept 27, 1930, that I last saw her alive on Sept 27th, 1930, and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

(uraemia 8 days)

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) diabetes mellitus

(duration) 20 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical signs & blood tests

(Signed) Gordon Mahurin, M. D.

, 19 (Address) 715 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount

DATE OF BURIAL Sept 29th 1930

20 UNDERTAKER Henry H. Jenkins Sons Co

ADDRESS McCulloh & Orchard

THOMPSON JONES, M.

-30—M. & T.—100 B—50L

E 60930

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 ✓ E 60930

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 16-13 (WARD)

2-FULL NAME Samuel Becker

(a) RESIDENCE NO 1414 E. Chase ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy Becker

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1434 E. Balto., St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombus

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..... M. D.
Coroner

9/29/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Woods

DATE OF BURIAL 9-24-1930

20 UNDERTAKER Jack Lewis, 1431

ADDRESS Jack Lewis

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 60931

E 60931

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 1537 N. Wolfe ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Baker Wheeler

(a) RESIDENCE NO. 1537 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Wheeler

DATE OF BIRTH (month, day, and year) Nov. 3rd 1879

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	10	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tally Clerk 004

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping

(c) Name of employer General

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John J Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Susan V. Clacker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary Co Md

Informant Wm W. Wheeler (Brother)

(Address) 2004 E Federal

Filed 1 1 39 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28-1930

17 I HEREBY CERTIFY, That I attended deceased from June 20- 1930, to Sept 28 1930, that I last saw him alive on Sept 27 1930 and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Tuberculosis

Mitral Regurgitation Decompensated

(duration) yrs. 3 mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X Ray.

(Signed) Thos. Fa Stevens, M. D.

9/28. 1930 Address) 2878 Walford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL 10/1/30 19

20 UNDERTAKER George J Bath Son

ADDRESS 1735 Harford

JAMES H. JONES, M. D.

P 29 1930

ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60932

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Angeline Dalesio

(a) RESIDENCE NO. 1905 Monumental Rd ST., Dundalk WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of Raphael Dalesio

DATE OF BIRTH (month, day, and year) 7-22-1887

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43 years.	2	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Guglielmo Fiore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mariano Fiore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Records M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28-1930

17 I HEREBY CERTIFY, That I attended deceased from 4/22/30, 19..., to Sept. 28, 19 30, that I last saw her alive on Sept 28, 19 30, and that death occurred, on the date stated above, at 6 05 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - Malignant Sarcoma bone - Left parietal - temporal bone

(duration) ... yrs. 1? mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 9-24-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Fred W Keil, M. D.

9/29 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 10/1/30 19

20 UNDERTAKER George J Boltz Son

ADDRESS 1735 Harford

ec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

60933

CERTIFICATE OF DEATH.

129 E 60933

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 1819 - Hope St ST. 9-16 WARD)

2-FULL NAME Anna Schaffer

(a) RESIDENCE NO. 1804 - Aiken St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Schaffer

DATE OF BIRTH (month, day, and year) 11/9/1864

AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	65	10	20	X

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Samuel G. Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John G. Schaffer (Address) 1804 - Aiken St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29-30

17 I HEREBY CERTIFY, That I attended deceased from 6/24, 1930, to 9/29, 1930, that I last saw her alive on 9-29, 1930, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic Int Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Dan Fraser M. D.

9/29 1930 (Address) 150 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 10/1/30 19

20 UNDERTAKER Geo. J. Roth Sons

ADDRESS 1735 Hanford

c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60934

CERTIFICATE OF DEATH.

51 E 60934

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 E. 32nd. St. ST. 9-46 WARD)

2-FULL NAME William J. Lutts

(a) RESIDENCE NO. 1629 E. 32nd. St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth G. Lutts

DATE OF BIRTH (month, day, and year) April 13th. 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	5	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police Sergeant.

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer Balto. Police Dept.

BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Lutts.

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Cecelia Pendergast

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Elizabeth G. Lutts.

(Address) 1629 E. 32nd. St.

15 Filed 9/29/30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27th. 1930

17 I HEREBY CERTIFY That I attended deceased from 1922, to Sept 27, 1930, that I last saw him alive on Sept 26, 1930, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Blood

(Signed) Edward Geary, M. D.

9/29, 1930 (Address) 705 Med Arts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL Sept. 30, 30

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 1118 N. Mt Royal Ave

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

60935

CERTIFICATE OF DEATH

90 E 60935

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1425 W Royal (St.) (Ward)

2-FULL NAME Margie E McCloskey

(a) RESIDENCE NO 1226 W Royal ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W

6 DATE OF BIRTH (month, day, and year): Sept 2-1903

7 AGE: Years 27 | Months — | Days 26 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Hiram Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lena Wyatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: John McCloskey

(Address): 1225 W Mt Royal

15 Filed ....., 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

Signed: H. B. Kirk, M. D. Coroner

City (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: Oct. 31 1930

20 UNDERTAKER: Chas R Kane & Son

ADDRESS: 1 W Mt Royal Ave

ec.—1-30—M. & T.—250 Bks.

720

E 60936

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 60936

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horton Tilliverson

(a) RESIDENCE NO. 1433 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Clemme

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Wilkerson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER — Wilkerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 27/30

17 I HEREBY CERTIFY, That I attended deceased from September 16, 1930 to September 27, 1930, that I last saw h/A alive on September 27, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriolar sclerosis, Hypertension Cardiac Hypertrophy, Arteriolar nephritis, Chr.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia. Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood chemistry

(Signed) Caroline C. Bedell M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phenix Va

DATE OF BURIAL 9/30 1930.

20 UNDERTAKER B. F. Williams

ADDRESS 1515 McElderry

-30—M. & T.—100 B—56L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60937

60937.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 9-17 WARD)

2-FULL NAME Marie B. Witt

(a) RESIDENCE NO Dieter Ave., Fullerton, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26/1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Daugherty

11 BIRTHPLACE OF FATHER (city or town) Balto. Co., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Martin

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co., Md.
(State or country)

14 Informant Baltimore, Md.
(Address)

15 Filed ..... 192 ..... Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 27/3 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to her death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Heart Disease

7 mons. pregnancy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John L. Caccese, M. D.
Coroner

, 19 (Address) 1600 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Sept. 30 1930

20 UNDERTAKER Fred'k Lassahn & Sons

ADDRESS 7401 Belair Rd.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60938

E 60938

CERTIFICATE OF DEATH.

154-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1222 N. Potomac St. St. 8-11 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Rietzer

(a) RESIDENCE No 1222 N. Potomac St St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26-1930

7 AGE — Years — Months — Days: 1

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1222 N Potomac St.

PARENTS

10 NAME OF FATHER Fredrick H. Rietzer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Agatha Owens.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant
(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Sept 26, 1930, that I last saw h[illegible] alive on Sept 26, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale.
Blue Baby.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Insufficient Data.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John L. Geyer, M. D.

, 19 (Address) 136 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: SEP 29 1930 19

20 UNDERTAKER: [illegible] Bear Health — ADDRESS

C. HAMPSON JONES, M. D.

SEP 29 1930

Registrar

ec.—1-12-23—M&T—500 Bks.

E 60939

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60939

CERTIFICATE OF DEATH

100-001

REGISTERED NO. .....

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No. 1222 Caton Ave ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret R. Hild

(a) RESIDENCE NO. 2924 Clifton Ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1847

AGE: Years 83 yrs. Months ..... Days ..... If LESS than 1 day, hrs or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia (State or country) Pa.

PARENTS

10 NAME OF FATHER David Mc Gargh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Jenkins Mem. Hosp. (Address) 1222 Caton Ave

15 Filed ..... 19 ..... Registrar .....

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27 1930

17 I HEREBY CERTIFY, That I attended deceased from September 11, 1930, to September 27, 1930, that I last saw her alive on Sept 27, 1930, and that death occurred, on the date stated above, at 7.15 A m. C. S. T.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mns 5 ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mns. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs

(Signed) Robt Dewees, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL Sept 30, 1930

20. UNDERTAKER John J Fahey Sons ADDRESS 1318 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60940

CERTIFICATE OF DEATH.

E 60940

REGISTERED NO. 161-60 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3432 2nd St. 25-7 WARD)

2-FULL NAME Michael Patrick Frank, 2nd

(a) RESIDENCE NO. 3432 2nd St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 3432 2nd St Baltimore Md

PARENTS

10 NAME OF FATHER Arthur M. Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middletown Pa.

12 MAIDEN NAME OF MOTHER Mary Stanny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant: Father

(Address)

15 Filed SEP 29 1930, 19 C. HAMPSON GIBBONS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1930, to Sept. 27, 1930, that I last saw he alive on Sept. 27, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Premature birth,

Mal Adjustment

lived 1 hour

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur M. Frank, M. D.

, 19 (Address) 1213 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: State Board of Health

DATE OF BURIAL: SEP 29 1930

20 UNDERTAKER: Director of Health.

ADDRESS

sec.—1-30—M. & T.—250 Bks.

E 60941 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60941

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE; (No. Mt Royal Hotel St. 11-19 WARD)

2-FULL NAME Benjamin Bissell

(a) RESIDENCE NO. Mt Royal Hotel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 77 yrs. 9 mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Bessie Henshaw Bissell

DATE OF BIRTH (month, day, and year) Dec. 31, 1852

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	9	27	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work General Manager
(b) General nature of Industry, business, or establishment in which employed (or employer) Executive
(c) Name of employer Century Coal Co -

BIRTHPLACE (city or town) Bel Air
(State or country) Md -

PARENTS
10 NAME OF FATHER Wm. R. Bissell
11 BIRTHPLACE OF FATHER (city or town) Norfolk
(State or country) Va.
12 MAIDEN NAME OF MOTHER Margaret Webster
13 BIRTHPLACE OF MOTHER (city or town) Bel Air
(State or country) Md

14 Informant Phoebe A. Bissell
(Address) Mt. Royal Apts -

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.
9-19-30

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1925, to Sept 28, 1930, that I last saw him alive on Sept 28, 1930, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis

and more
(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis
(duration) ... yrs. 4 mos. 19 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? Blood pressure, physical signs
(Signed) Chas Clapp M. D.
19 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Spring Harford Co Md	Sept 30 1930
20 UNDERTAKER Henry Hopkins & Co	ADDRESS Eutaw & McCulloh

...c.—1-30—M. & T.—250 Bks.

E 60942 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60942

CERTIFICATE OF DEATH. 16-002

REGISTERED NO.

1-PLACE OF DEATH
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) St Elizabeth's Home ST., 9-47 WARD)

2-FULL NAME Sister Mary Germaine (Catherine Fogg)

(a) RESIDENCE NO. St. Elizabeth's Home ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1854?

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
76 ?				

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Religious
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) England

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant St. Elizabeth Home
(Address) Chestnut Hill ave

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from September 26 1930, to September 27, 1930, that I last saw her alive on September 27, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bacillary Dysentery

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Genuine Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Ayd, M. D.

Sept 29, 1930 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Elizabeth Cemetery Ellicott City

DATE OF BURIAL Sept 30 1930

UNDERTAKER Henry Jenkins & Sons

ADDRESS Ellicott City Md

C. HAMPSON JONES, M.

Dec.—1-12-23—M&T—500 Blks.

E 60943

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60943

CERTIFICATE OF DEATH.

90

REGISTERED NO. 15-18

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2704 Westwood Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Svrcjcek

(a) RESIDENCE NO. 2704 Westwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Svrcjcek

6 DATE OF BIRTH (month, day, and year): April 18, 1858

7 AGE: Years 72; Months 5; Days 10; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: John Haydock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs Rose Hengler 2704 Westwood Ave

15 Filed . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930, to Sept 27, 1930

that I last saw her alive on Sept 27, 1930

and that death occurred, on the date stated above, at 5-45 52 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Endocarditis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. Magee, M. D.

9/29 1930 (Address) 26 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cemetery

DATE OF BURIAL: Oct 1. 1930

20 UNDERTAKER: Edmund W. Conklin

ADDRESS: 1248 E Eager St.

ec.—2-29-28—L. F. S.—500 Bks.

E 60944

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 60944

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2506 Southern Ave ST., 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie C. Fisselberger

(a) RESIDENCE NO. 2506 Southern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~. (Write the word)
F.	W.	Widow

If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm. Fisselberger

DATE OF BIRTH (month, day, and year) May 4 1853

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	6	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER — Wiechert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Bessie Fisselberger

(Address) 2506 Southern Ave

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to Sept. 28, 1930, that I last saw her alive on Sept. 28 1930 and that death occurred, on the date stated above, at 6-30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Chronic myocarditis

Arteriosclerosis

over 5 (duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) J. M. Bacon, M. D.

9/29. 1930 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Oct 1 1930

20 UNDERTAKER P. Strand Gore — ADDRESS 1723 W. Lafayette Ave

-30—M. & T.—100 B—50L

E 60945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

2743 24-001

E 60945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5501 Carter Ave ST., WARD

2-FULL NAME Charles B. Storke

(a) RESIDENCE NO 5501 Carter Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Storke

6 DATE OF BIRTH (month, day, and year) Aug 3/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	1	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) House
(c) Name of employer Samuel Conn

9 BIRTHPLACE (city or town) (State or country) Betterton, Md.

PARENTS

10 NAME OF FATHER Daniel T. Storke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co., Md.

12 MAIDEN NAME OF MOTHER Elizabeth Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co., Md.

14 Informant Mrs. Lottie Storke.

(Address) 5501 Carter Ave.

15 Filed ..... 192 ..... Registrar

1930 HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 27/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Continental Tr. Bldg.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Walker, M. D. Coroner

9/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Sept 30 1930

20 UNDERTAKER Wm. C. Black

ADDRESS 927 W. Broadway

ec.—2-29-28—L. F. S.—500 Bks.

E 60946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-00 E 60946

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 117 N. Lakewood Ave. ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James T. Dean

(a) RESIDENCE NO. 117 N. Lakewood Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Dean

DATE OF BIRTH (month, day, and year) Oct. 25, 1836,

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	93	11	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Annie F. Simmons

(Address) 117 N. Lakewood Ave.

15 Filed ..., 19 ... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1930, to Sept 28, 1930,

that I last saw h... alive on Sept 28, 1930

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Senility. Arteriosclerosis (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B Lemmon M. D.

9/30, 1930 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Sept. 30, 1930,

20 UNDERTAKER Wm. C. Black

ADDRESS 927 N. Broadway

Dec.—1-30—M. & T.—250 Bks. Dr Bowden 1517 E. North Ave Var 1653

E 60947 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60947

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 419 E. Biddle ST. 11-15 WARD)

2-FULL NAME Sallie May Berry

(a) RESIDENCE NO. 419 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If ~~married, widowed, or divorced~~ HUSBAND of or) WIFE of Frank T. Berry

6 DATE OF BIRTH (month, day, and year) Feb 26th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John P. Delphey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Delola Koontz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John P. Sumnott

(Address) 419 E. Biddle St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/3/, 1930, to 9/28/, 1930,

that I last saw her alive on 9/27/, 1930,

and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis - general abdominal.

2 (duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Toxaemia.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Lab

(Signed) George A. Bowden M. D.

9/29/, 1930 (Address) 1517 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Bridge Md Cemetery

DATE OF BURIAL 10/1/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

~~9/30/1930 C. HAMILTON JONES, M. D.~~

Wakeman

-30—M. & T.—100 B—50L

E 60948

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60948

CERTIFICATE OF DEATH

89

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3617 Glenmore Ave ST. 27-43 WARD)

2-FULL NAME Llewellen B. Wakeman

(a) RESIDENCE NO 3617 Glenmore Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of Ida Maye Wakeman
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 30/1873

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	57	5	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Weather Stripper
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Connecticut

PARENTS

10 NAME OF FATHER Daniel Wakeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Ida Maye Wakeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant Daily Bell

(Address) 3617 Glenmore Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 28/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
(Coronary Angina Pectoris)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. S. Wallis, M. D.
Coroner

9/29/30, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park Lane

DATE OF BURIAL Sep 30 1930

20 UNDERTAKER W. M. Cook

ADDRESS 1217 St Paul St

pec.—1-30—M. & T.—250 Bks. Dr Knox Insley Balto & Potomac sts Wolf 4863

E 60949

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60949

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Elrino ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen D. Sachs

(a) RESIDENCE NO. 1604 Elrino ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) Mar 8th 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John H. Sachs

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Edna E. Erdman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant John H. Sachs (Address) 1604 Elrino st

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, to Sept 28, 1930, that I last saw h[e] alive on Sept 23, 1930, and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? not Date of

Was there an autopsy? no

What test confirmed diagnosis? clinic

(Signed) Wilson Guiley, M. D.

9-29-30 (Address) 522 E Mass

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL 9/30/1930

20 UNDERTAKER Wm Cook

ADDRESS 1211 St Paul st

1-30—M. & T.—100 B—50L

E 60950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60950

REGISTERED NO. +29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

2-FULL NAME William Smith

(a) RESIDENCE No 144 Winters Ave. ST. Catonsville, Md. WARD,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Catonsville School

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md

PARENTS

10 NAME OF FATHER Alexander Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ella Smith

(Address) 144 Winters Ave.

15 C. HAMPSON JONES, M. D.

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Tetanus - due to gunshot wound of right hand. Accidental (duration) 4 days mos ds

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D. Coroner

9/29, 19 30 (Address) 2739 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star Cem

DATE OF BURIAL: Oct 1 19 30

ADDRESS: Baltimore

20 UNDERTAKER: Samuel Kemsley

ec.—8-16-29—L. F. S.—100 Bks.

E 60951

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60951

CERTIFICATE OF DEATH

REGISTERED NO. 77-48

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 606 Nicoll Ave ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John C Erhardt

(a) RESIDENCE NO. 606 Nicoll Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State) Harriman, N. Y.

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced) HUSBAND of (or) WIFE of: Emily Erhardt

DATE OF BIRTH (month, day, and year): Oct 16, 1875

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	5	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Richard Talbot

BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: John A Erhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Strohecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Theresa Erhardt

(Address): 606 Nicoll Ave

15 Filed ..., 19 ... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1930, to Sept 29, 1930, that I last saw him alive on Sept. 29, 1930, and that death occurred, on the date stated above, at 3:27 p. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

Don't Know Visitor Prof. several yrs (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? New York State

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hess, M. D.

Sept 29 1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harriman N.Y.

DATE OF BURIAL: 9/30/1930

20 UNDERTAKER: J M Cook

ADDRESS: 1217 Druid Hill Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60952

CERTIFICATE OF DEATH.

90 E 60952

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 6016 Eastern Ave St. 26-37 Ward)

2-FULL NAME Andrew Smolinski

(A) RESIDENCE NO. 356 Cornwall St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Smolinski

6 DATE OF BIRTH (month, day, and year) Dec. 25 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	39	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Boiler Maker

(c) Name of employer Forman

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Smolinski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Rose Smolinski

(Address) 356 Cornwall St.

15 Filed ....., 19 ..... Registrar

SEP 9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

Sept 29/30

(Duration) ..... yrs. ..... mos. 1 ds.

Signed C. Ramson Jones M. D.

(Coroner)

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Cross German Hill Cem. Oct 1 1930

20 UNDERTAKER ADDRESS

Otto M. Weber 4041 Harford

very important. See instructions on back.

pec.—1-30—M. & T.—250 Bks

E 60953

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60953

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., 3-9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McKay.

(a) RESIDENCE NO. 32 N. Caroline ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) July 4, 1892

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal trimmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Peter McKay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Nancy Douglas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Regards N. (Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to Sept. 26, 1930, that I last saw him alive on Sept 26, 1930, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Heart disease,
Rheumatism

more than (duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Padget, M. D.

9-27, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interment Loem

DATE OF BURIAL 10-1 1930

20 UNDERTAKER John H. Henderson

ADDRESS 1602 E. Monument St

ec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60954

CERTIFICATE OF DEATH.

129 E 60954

REGISTERED NO.

1-PLACE OF DEATH Balto. City Hospitals ST 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Charles Parran

(a) RESIDENCE NO. 1000 Low ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Dec. 2, 1888

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick yard work

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Jerry

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Wallace

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-30

17 I HEREBY CERTIFY, That I attended deceased from 9-27-30, 19..., to 9-27-30, 19...,

that I last saw h... alive on 9-27-30, 19...,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, without oedema.

Uraemic Coma.

(duration) more than yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padgett, M. D.

9-29, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interment Leeds

DATE OF BURIAL 10-2-30

20 UNDERTAKER Jas. Wm. Skinner

ADDRESS 1626 E. Lnad St

1-30—M. & T.—100 B—50L

E 60955

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/1 E 60955

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1818 Division St. 14-20 WARD)

2-FULL NAME James O Denton

(a) RESIDENCE NO 1818 Division ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Mar 8-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jasper Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lillian Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Lillian Burton

(Address) 1818 Division

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Pulmonary Phthisis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signature) Harold Hamburger, M. D.
Coroner

(Address) Coroner

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL Sept 30 1930

20 UNDERTAKER Virginia A. Brooks | ADDRESS 1463 N Carey St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60956

CERTIFICATE OF DEATH.

35 E 60956

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1513 mosher ST. 16-22 WARD

2-FULL NAME Pearl Estelle Grant

(a) RESIDENCE NO. 1513 mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	7 22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William D Grant

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Tait

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) William Grant 1513 Mosher St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930, to Sept 29, 1930, that I last saw her alive on Sept 28, 1930, and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Tuberculous Abscess of Left Knee joint

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Drainage Date of Sept 27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dr Bernard L Grant M. D.

9/29, 1930 (Address) 1513 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn DATE OF BURIAL: Sept 30 1930

UNDERTAKER: Virginia C Brooks ADDRESS: 1463 N. Carey

Spec.—8-16-29—L. F. S.—100 Bks.

E 60957 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60957

CERTIFICATE OF DEATH

REGISTERED NO. 47

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 715 Cumberland ST. 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Johnson

(a) RESIDENCE NO. 715 Cumberland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Johnson

6 DATE OF BIRTH (month, day, and year) Jan 17 80

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8	12	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Southampton Co. Va

PARENTS

10 NAME OF FATHER Wm Humphrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Southampton Co Va

12 MAIDEN NAME OF MOTHER Ellen Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Southampton Co Va

14 Informant Jennie Tate

(Address) 715 Cumberland St

15 Filed SEP 30 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1930, to Sept 28, 1930, that I last saw h[illegible] alive on Sept 27, 1930 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Fistrue - Metastasis -

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Breast Left

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 30, 1929

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) Wm H Wright, M. D.

9/8, 19 30 (Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg, Va.

DATE OF BURIAL 10/1/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Dumbarton Hill

pec.—1-30—M. & T.—250 Bks

E 60958

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60958

CERTIFICATE OF DEATH.

REGISTERED NO. 1-001

1-PLACE OF DEATH Baltimore City Hospitals ST. 14-30 WARD

CITY OF BALTIMORE: (No.

2-FULL NAME Helen Miller

(a) RESIDENCE NO. 1813 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6 If married, widowed, or divorced (or) WIFE of David

7 DATE OF BIRTH (month, day, and year) July 1, 1910

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Carter

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Annie Bizens

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant (Address) Records of Balto. City Hosp.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-28-30

17 I HEREBY CERTIFY, That I attended deceased from 9-21-30, 19, to 9-28-30, 19,

that I last saw her alive on 9-28-30, 19,

and that death occurred, on the date stated above, at 11:15 A m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy, Culture.

(Signed) Dave Padget, M. D.

9-29 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Lutindale

DATE OF BURIAL 10/1/1930

ADDRESS

20 UNDERTAKER Mrs. Geo. F. Holland 1631 Linwood Ave

9-29-1930 H. [illegible] JONES, M. D.

pec.—1-30—M. & T.—250 Bks.

50 P

HEALTH DEPARTMENT—CITY OF BALTIMORE

60959 — 127 — E 60959

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1116 N. Washington ST. 5-13 WARD)

2-FULL NAME Michael Rierauf

(a) RESIDENCE NO. 1116 N. Washington ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Rierauf

7 DATE OF BIRTH (month, day, and year) 2.2.1855.

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	75	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Restaurant Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anthony Eberle

(Address) 1116 N. Washington St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9.28.30.

17 I HEREBY CERTIFY, That I attended deceased from October 28 19 ... to September 28 19 30.

that I last saw him alive on September 26 19 30.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

(a) Cirrhosis of Liver

(b)

(c)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Edema, Dropsy

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Paul H. A. Meyer M. D.

9/29 19 30. (Address) 10 7/12 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer Cemetery	Oct. 1 19 30
20 UNDERTAKER Henry Hoeck & Son Inc.	ADDRESS 1301 E. Eager St

Spec.—1-10-21—MAT—1500 Blks.

E 60960 HEALTH DEPARTMENT—CITY OF BALTIMORE 118-0 E 60960

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1600 Vincent ST. 15-21 (WARD)

2-FULL NAME Emma Mitchell

(a) RESIDENCE NO. 1600 Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Mitchell

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 45 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Caterer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queens Anne Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emma Mitchell (Address) 1600 Vincent

15 SEP 30 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Sept 28, 1930, that I last saw him alive on Sept 27, 1930, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

CONTRIBUTORY (Secondary) Left Inguinal Hernia (duration) 2 yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

9-28 1930 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL Oct 1 1930

20 UNDERTAKER Sam'l N. Chase Sons | ADDRESS Has Mother

pec.—1-12-23—M&T—500 Bks.

E 60961 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60961

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 W. Mulberry ST. 13-26 WARD)

2-FULL NAME John Henry Larkins

(a) RESIDENCE NO. 718 W. Mulberry ST., 4 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Ella Larkins

6 DATE OF BIRTH (month, day, and year) 1825 Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
105			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Stevedore

(c) Name of employer M. L. Carey Canton Tinder Co

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER J. Alerson Larkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Hester Larkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hattie Hand
(Address) 718 W. Mulberry St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 29 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/17/, 1930, to 9 29, 1930.

that I last saw him alive on 9 29, 1930.

and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation
Pulmonary Hypostasis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Para Chymatus (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) W. H. Bishop M. D.

, 19 (Address) 719 Stuart St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lexington Va.

DATE OF BURIAL 10/1/1930

20 UNDERTAKER Leon H. Evans Son

ADDRESS Lexington Va.

pec.—1-30—M. & T.—250 Bks.

240806 E 60962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37-001 E 60962

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-4-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Romulus Curry

(a) RESIDENCE NO. 2024 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or (b) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 4 - 1930

7 AGE — Years: — Months: 7 Days: 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child pd

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Romulus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Susie Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1930 to Sept 28, 1930, that I last saw him alive on Sept 28, 1930, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

miliary tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) tuberculous meningitis

(duration) yrs. ½ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? lumbar puncture

(Signed) Robert O. G. Warner, M. D.

9/29, 1930 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: White Stone Md.

DATE OF BURIAL: Sept 30 1930

20 UNDERTAKER: Daniel Easton

ADDRESS 96 Park ave

pec.—1-30—M. & T.—250 Bks.

E 60963 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60963

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 917 Edmondson Ave ST., 26 WARD)

2-FULL NAME James Allen

(a) RESIDENCE No. 1 Robertson Station Md WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Mattie Allen

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mattie Allen
(Address) 917 Edmondson Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Sept 28, 1930, that I last saw him alive on Sept 21, 1930, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows: Cancer of Liver

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Robertson Station Md

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John D. Gainer M. D.

, 19 (Address) 1421 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 9-30 1930

20 UNDERTAKER David Earhart

ADDRESS 916 Ea Ave.

SEP 30 1930 HAMILTON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 60964 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 60964

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bklo City Hospls
CITY OF BALTIMORE: (NO. Balto 2nd ST., 16-26 WARD)

2-FULL NAME John De Shields

(a) RESIDENCE NO. 615 Carlton ST. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Black
5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary De Shields

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records City Hosp.
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-28-30

17 I HEREBY CERTIFY, That I attended deceased from 10-25-, 1926, to 7-28, 1930,
that I last saw him alive on 9-28, 1930,
and that death occurred, on the date stated above, at 5.35 A m.

The CAUSE OF DEATH* was as follows:
Terminal Bronchopneumonia
(duration) ..... yrs. ..... mos ..... da.
CONTRIBUTORY (Secondary) Senile Psychosis (interval)
Chronic Myocarditis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

9/29 1930 (Signed) Harry Feldmeth M. D.
(Address) Balto City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem
DATE OF BURIAL 10/1 1930
20 UNDERTAKER Arnold S. Tinsley
ADDRESS 1538 Madison

Spec.—1-30—M. & T.—250 Bks.

E 60965

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60965

3 1 ✓

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. St. 6-10 Ward)

2-FULL NAME Rebecca Katz

(a) RESIDENCE NO. 15 N. Collington Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Isaac Katz

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 55; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Emanuel Katz (Son)
(Address) 8 Market Place

15 Filed....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1930, to Sept. 29, 1930,

that I last saw her alive on Sept 29, 1930,

and that death occurred, on the date stated above, at 1:15 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Diabetes mellitus

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Martin Myers, M. D.

, 19 (Address) 1500 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Sinai Memorial Park

DATE OF BURIAL: 9-30- 1930

20 UNDERTAKER: Jacob Levin, 1431

ADDRESS: E. Baltimore St.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60966 — 90 E 60966

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831- N. Fremont Ave ST. 17-23 WARD)

2-FULL NAME William Augusta Riley

(a) RESIDENCE NO. 831- N- Fremont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Annie Riley

6 DATE OF BIRTH (month, day, and year): May 28, 1880

7 AGE — Years: 50 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Benjamin Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Centreville, Md.

12 MAIDEN NAME OF MOTHER: Sarah Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norfolk Va

14 Informant: Annie R. Riley
(Address): 831 N Fremont Ave

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-28 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-25-, 1930, to 9-28, 1930, that I last saw him alive on 9-28, 1930 and that death occurred, on the date stated above, at 11 40 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease, cerebral embolism,

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Valvular Heart disease (duration) about yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) C. L. Jackson M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — DATE OF BURIAL: Oct 2, 1930

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 322 N Schroeder St

E 60967

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60967

CERTIFICATE OF DEATH.

REGISTERED NO. 945

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lyndenham Hosp. 4th WARD)

2-FULL NAME Margaret Cuffley

(a) RESIDENCE NO. 5th Ave., Sandtowne, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co. (State or country)

PARENTS

10 NAME OF FATHER Dewey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Clara Rosenberger

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant (Address) father of deceased 5th Ave. Sandtowne Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1930, to Sept 29, 1930, that I last saw h[illegible] alive on Sept. 29, 1930, and that death occurred, on the date stated above, at 11:40 A m.

The CAUSE OF DEATH* was as follows:

Nasal, Laryngeal, Laryngeal Diphtheria

(duration) 0 yrs. 0 mos 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Failure

Sudden (duration) 0 yrs. 0 mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Laboratory

(Signed) Joseph H. Shain, M. D.

, 19 (Address) Lyndenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 30 1930

20 UNDERTAKER: Vernon Kechner — ADDRESS: Hollins

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60968

CERTIFICATE OF DEATH

90 ✓ E 60968

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2610 Hudson street St., 1-3 Ward)

2-FULL NAME Anna Melenko

(a) RESIDENCE NO. 2610 Hudson st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Szczepan Melenko

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Wife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Jack Krweszyk

11 BIRTHPLACE OF FATHER (city or town) poland
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Szczepan Melenko
(Address) 2610 Hudson st

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) C. Blades, M. D.

, 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Oct 2nd 1930
20 UNDERTAKER George A. Weber	ADDRESS 705 S. Ann.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

pec.—1-30—M. & T.—250 Bks.

60969 E 60969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hospitals ST. 23-33 WARD)

2-FULL NAME Lelia Widmayer

(a) RESIDENCE NO. 23 Poultney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Laurence Widmayer

6 DATE OF BIRTH (month, day, and year): Apr 16 1875

7 AGE: Years 67; Months 75; Days 2613; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hancock Md.

PARENTS

10 NAME OF FATHER: William Lowe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Power

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Walter Widmayer (Address) 29 Poultney St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-29-30

17 I HEREBY CERTIFY, That I attended deceased from 9-25, 19 30 to 9-29, 19 30.

that I last saw her alive on 9-29, 19 30

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix of Uterus

c Regional Metastasis

(duration) 2 yrs. mos ds. (?)

CONTRIBUTORY (Secondary) Terminal Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy & clinical

(Signed) Luther E. Leede, M.D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: 10/1 1930

20 UNDERTAKER: Wilhelm Bohl

ADDRESS 1217 E. Lexington St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60970

CERTIFICATE OF DEATH.

118-001

E 60970

1-PLACE OF DEATH 1259 Carroll St.

City of BALTIMORE: (No. 1259 Carroll St 21-29 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minnie Westphal

(a) RESIDENCE NO. 1259 Carroll St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of August Westphal

6 DATE OF BIRTH (month, day, and year) June 16, 1849

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	81	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr August Westphal

(Address) 1259 Carroll St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1930, to Sept. 30, 1930, that I last saw h.. alive on Sept. 30, 1930, and that death occurred, on the date stated above, at 4.15 A.m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia Right Side

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Large Hernia (Right) (Irreducible for one year)

(duration) 15 yrs. ..... mos. ..... ds.

18 Where was disease contracted —

If not at place of death? .....

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? none necessary

(Signed) Harry Kate, M. D.

, 19 (Address) 523 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

Date of Burial Aug 2 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

very important. See instructions on back of certificate.

Spec. 8-16-29—L. F. S.—100 Blks.

E 60971 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60971

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4505 La Salle Ave ST.) (WARD) 26-42

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Winkler Stahrer

(a) RESIDENCE NO. 4505 La Salle Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced (or) WIFE of Henry Stahrer

7 DATE OF BIRTH (month, day, and year) Dec 11 1853

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	17	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

10 BIRTHPLACE (city or town) Perry Hall (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Anthony Buth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Buttle (Address) 46 Cooke ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1930, to Sept 28, 1930, that I last saw h[illegible] alive on Sept. 27, 1930, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Typical symptoms

(Signed) H. Lloyd Livingwood M. D.

9/29, 1930 (Address) 1613 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lloyd (Fullerton) DATE OF BURIAL Oct 1 1930

20 UNDERTAKER L. J. Rauch ADDRESS 4405 Harford

Spec.—1-30—M. & T.—250 Bks.

E 60972 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospitals ST. 3-4 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lee

(a) RESIDENCE NO. 505 N. Caroline ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND) of or) WIFE of Rose Lee

6 DATE OF BIRTH (month, day, and year) July 10 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	2	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER William Lee

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Rose Lee
(Address) 505 N. Caroline St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-30

17 I HEREBY CERTIFY, That I attended deceased from 5-20, 19 30, to 9-27, 19 30, that I last saw him alive on 9-27, 19 30 and that death occurred, on the date stated above, at 5-05 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with Hepatic Metastasis

(duration) yrs. 4 mos da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Luther E. Cole M. D.

19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pasadena county

DATE OF BURIAL Oct 1 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Washington

Spec.—1-30—M. & T.—250 Bks

E 60973 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60973

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 1724 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Buchanan

(a) RESIDENCE NO. 924 Argyle Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooking

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Jacob

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Roeder

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-30

17 I HEREBY CERTIFY, That I attended deceased from 9-22-30, 19..... to 9-27-30, 19.....

that I last saw her alive on 9-27-30, 19.....

and that death occurred, on the date stated above, at 4:20 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, arteriosclerotic

(duration) UNKNOWN. yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 6 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

9-27, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Oct 1, 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1725 Eastern Ave

DEC 1930 C. HAMPSON JONES, M.

Spec.—1-30—M. & T.—250 Bks.

E 60974

E 60974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2331 Madison ave ST. (or) WARD) 12-59

2-FULL NAME Ella Band

(a) RESIDENCE NO. 2331 Madison ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of Walter Band.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Birthplace Va.

PARENTS

10 NAME OF FATHER Henry Holly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hester Holly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Ernestine Winston

(Address) 2331 Madison ave

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, '30.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Sept. 27, 1930, that I last saw h.. alive on Sept. 27, 1930, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. —

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. N. Pigott, M. D.

9/30, 1930 (Address) 1536 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary DATE OF BURIAL Oct 1, 1930

20 UNDERTAKER Mrs. P. G. Elliott ADDRESS 1745 Madison ave

pec.—1-30—M. & T.—250 Bks

E 60975

E 60975

HEALTH DEPARTMENT—CITY OF BALTIMORE

51

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 1-3 ST. ..... WARD)

2-FULL NAME Sophie Milkowski (Zofia Milkowska)

(a) RESIDENCE NO. 2733 Dillon ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? 87

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER George Milkowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Evans

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-30

17 I HEREBY CERTIFY, That I attended deceased from 9-27-30, 19..... to 9-27-30, 19.....,
that I last saw her alive on 9-27-30, 19.....,
and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic fever
(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis, acute
(duration) yrs. ..... mos. 17 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padgett M. D.

9-28 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL Oct. 2 1930

20 UNDERTAKER Stefan Falkowski

ADDRESS 1000 E. Lemmon

1-30—M. & T.—100 B—50L

E 60976

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60976

CERTIFICATE OF DEATH

REGISTERED NO. 191

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 N. Pine ST., 4-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Merrick

(a) RESIDENCE NO 316 N. Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Merrick

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Samuel Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maggie Breger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edward Merrick

(Address) 718 W. Franklin St.

15 Filed ..., 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to pistol shots of left lung & inferior Vena Cava. Homicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene Ellis Coroner, M. D.

9/29, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Sept 30, 1930

20 UNDERTAKER Mrs Katie R Williams

ADDRESS 322 N Schroeder St

Spec.—1-12-23—M&T—500 Blks.

E 60977 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60977

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2128 Collington ave ST., 13 WARD)

2-FULL NAME James T. Barnett

(a) RESIDENCE NO. 212 N. Collington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Barnett

6 DATE OF BIRTH (month, day, and year) June 9 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie E. Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mary M Barnett

(Address) 212 N. Collington ave

15 Filed SEP 6 1930 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1930

17 I HEREBY CERTIFY, That I attended deceased from about June, 1927, to Sept 29, 1930, that I last saw h[illegible] alive on Sept. 27, 1930, and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocardial Nephritis and Myocarditis

about

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(duration) yrs. mos. 3 hrs ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical and Clinical

(Signed) Chas L. Mitchell, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Oct 1930

20 UNDERTAKER J. J. Moran

ADDRESS 3 East Baltimore

Spec.—1-30—M. & T.—250 Bks

E 60978 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-00 E 60978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hosp. REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Maudie Mc Bride

(a) RESIDENCE NO. 340 E 28 St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced [redacted] WIFE of Edward Mc Bride

6 DATE OF BIRTH (month, day, and year) March 12/891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston, Mass

PARENTS

10 NAME OF FATHER Albert Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edward Mc Bride

(Address) 340 E 28 St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28/30

17 I HEREBY CERTIFY, That I attended deceased from 9/28/30, 19 . to 9/28/30, 19 , that I last saw h.. alive on 9/28/30, 19 , and that death occurred, on the date stated above, at 7 26 [a.m./p.m.]

The CAUSE OF DEATH* was as follows:

Cerebro Thrombosis
Cerebral Hemorrhage

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Leyko, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 10/ 1930

20 UNDERTAKER C Vernon Lemmon

ADDRESS 661 Pk Hgts Ave.

OCT 1 1930

Cor.—10-10-29—A Co.—100 Bks.

E 60979

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60979

CERTIFICATE OF DEATH

REGISTERED NO. 16-68

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH West Balto Gen Hosp

City of Baltimore: (No.) St., 16 Ward)

2-FULL NAME Elsie M Eberle

(a) RESIDENCE NO. 606 Plymouth St., Ward Catonsville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of Rev. Henry J. Eberle

6 DATE OF BIRTH (month, day, and year) June 23-1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Coraopolis
(State or country) Penna

PARENTS

10 NAME OF FATHER Mikel J. Heinlein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Peeple

13 BIRTHPLACE OF MOTHER (city or town)
(State or country Coraopolis Penna

14 Informant Rev. Henry J. Eberle
(Address) 606 Plymouth Road

15 Filed 10/2 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto in which she was riding overturned @

(duration) Fract L. Femur yrs. mos. ds.

CONTRIBUTORY (Secondary) P. O. Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Raddellstown Md

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical + P.M.

(Signed) J. J. Stamm, M. D.

9/29 1930 (Address) 2434 W Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Coraopolis Penna — DATE OF BURIAL 10/2 1930

20 UNDERTAKER Gr. Weber + Son 2503 Edmondson Ave

See instructions on back of certificate. important.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60980

CERTIFICATE OF DEATH

REGISTERED NO. 113 E 60980

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 940 Bennett Pl. St., 18-K WARD

2-FULL NAME Mildred Howard

(a) RESIDENCE NO 940 Bennett Pl St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Col

5 If Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Apr 17 1928

7 AGE Years 1 Months 5 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leonard Howard

11 BIRTHPLACE OF FATHER (City or town) (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Ruth Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ruth Howard

(Address) 940 Bennett

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Status Epilepticus

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Bruce Taylor M. D. Coroner

(Address) 1 E Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sufcidal, or Homicfdal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on

C. HAMPSON JONES, M. D.

UNIVERSITY OF MARYLAND

School of Health

SEP 30 1930

SEP 30 1930

Spec.—1-30—M. & T.—250 Bks.

E 60981 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60981

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hospitals ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Rinehart

(a) RESIDENCE NO. 123 Aisquith St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 25th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	1	4 5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Rinehart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Kolb.

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs Lydia Wheeler (Address) Stemmers Run

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-30-30

17 I HEREBY CERTIFY, That I attended deceased from 06-10, 19 30, to 9-30, 19 30, that I last saw him alive on 9-30, 19 30, and that death occurred, on the date stated above, at 1:55 A.m.

The CAUSE OF DEATH* was as follows:

Fractured Left Femur Middle 1/3

Bilateral Pyo Nephrosis

(duration) yrs. 6 ? mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Luther E. Black, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 10/2/ 1930

20 UNDERTAKER Wm Cook 1217 St — ADDRESS Paul St

D 01930 HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

✓ Insley Balto. Potomac

E 60932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

E 60932

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 S. Montford Ave. WARD) 3

2-FULL NAME Geo. D. Webster Sr

(a) RESIDENCE NO. 839 S. Montford Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary Webster

6 DATE OF BIRTH (month, day and year) Oct 2nd 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper 415

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Harry Garrett + Sons

9 BIRTHPLACE (city or town) (State or country) Cleveland Ohio

PARENTS

10 NAME OF FATHER Chas Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George D. Webster Sr

(Address) 1914 Eutaw St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 19 to Sept 29 19

that I last saw h alive on Sept 28 19 30

and that death occurred, on the date stated above, at 10:10 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum + Intestines

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Finley M. D.

Sept 30 19 30 (Address) 2238 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 10/2/1930

20 UNDERTAKER William Cook

ADDRESS 1219 St Paul

65 =

1930 C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 60983 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60983

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. 512 ST., Eutaw WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina Celot

(a) RESIDENCE NO. 212 S Bouldin ST., WARD 2nd (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Peter Celot

6 DATE OF BIRTH (month, day, and year) Aug 2 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Isadora Cristina

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Teresa Pini

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Peter Celot

(Address) 212 S Bouldin St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-26-30 19 ..... to 9-30-30 19 .....

that I last saw h alive on 9-30-30 19 .....

and that death occurred, on the date stated above, at 12.45 a m.

The CAUSE OF DEATH* was as follows:

Appendicitis

7 (duration) ..... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Toxaemia & Vomiting (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9/24/30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) MB Vondrey, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 10/1/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

SEP 30 1930 C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 60984

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60984

CERTIFICATE OF DEATH.

REGISTERED NO. 132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp ST. 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Sampel

(a) RESIDENCE NO. 2043 E. Fairmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rachel Sampel

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ellis Sampel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 19 30, to Sept 30, 1930,

that I last saw h[illegible] alive on Sept 30, 1930,

and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Nephrolithiasis - left side

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Sept 30, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Cystoscopic, X-Ray

(Signed) Evelyn Steel Mun, M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Mt. Carmel

DATE OF BURIAL 10-1- 1930

ADDRESS

20 UNDERTAKER Jacob Levin 1439 Eutaw St.

C. HARRISON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 60985

E 60985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument & Rutland ave ST. H-25 (WARD)

2-FULL NAME Mr. Max Siegel

(a) RESIDENCE NO. 324 Pearl St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Gulda Siegel

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Meyer Siegel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Esther Freeman (Daughter)

(Address) 324 Pearl St.

15 Filed 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/28, 1930, to 9/30, 1930, that I last saw h/M alive on 9/30, 1930, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 9/30/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Friedman, M. D.

(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL 10-1-1930

20 UNDERTAKER Isaac Levin

ADDRESS 1431 Bank St

Spec.—1-30—M. & T.—250 Bks.

E 60986 HEALTH DEPARTMENT—CITY OF BALTIMORE 57 E 60986

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST. 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Annunciata Rebhan.

(a) RESIDENCE NO. Notre Dame Convent, Aisquith Street WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 4, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer Sisters of Notre Dame Baltimore Md.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Rebhan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Betz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant School Sisters of Notre Dame (Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930 to Sept 30, 1930, that I last saw her alive on Sept. 30, 1930, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Chronic Cholecystitis —

Chronic Cholelithiasis —

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home —

Did an operation precede death? yes Date of 9-29-30

Was there an autopsy? no —

What test confirmed diagnosis? Operation —

(Signed) A B Kinney, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodcliff Md. DATE OF BURIAL Oct 2 1930

20 UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60987

129 E 60987

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 822 E. 41 St. (WARD) 9-47

2-FULL NAME Thomas Foster Cooper

(a) RESIDENCE NO. 822 E. 41 St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary L. Cooper

6 DATE OF BIRTH (month, day, and year) Aug. 6, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Travelling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Leather 066

(c) Name of employer Retired 4 yrs.

9 BIRTHPLACE (city or town) (State or country) Bermuda Is

PARENTS

10 NAME OF ~~FATHER~~ Adolphus Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bermuda

12 MAIDEN NAME OF MOTHER Eliza Jane Newbold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bermuda

14 Informant Mrs. Mary C. Leonard

(Address) Brookeville, Md. R. 4

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1930, to Sept 28, 1930, that I last saw h[illegible] alive on Sept 28, 1930, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Contributory

(duration) 1 mo 2 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Walter A Cox, M. D.

Oct 2, 1930 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Oct 1930

20 UNDERTAKER W. J. McKnew Sons ADDRESS North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 60988

198 E 60988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 426 N. Cross St. St 21-31 Ward)

2-FULL NAME John E. Phillips. (C)

(a) RESIDENCE NO. 538 N. West St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ——— mos. ——— ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Phillips. (C)

6 DATE OF BIRTH (month, day, and year) March 11° 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	6	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER John Phillips. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary J ------ (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Minnie Phillips. (C) wife.
(Address) 538 N. West St.

15 Filed ..... 19..... Registrar

C. HARRISON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 27, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Internal Hemorrhage, due to stab wounds of the Heart and Lungs.
Homicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquest.

(Signed) Otto M. Leonhardt, M. D.

9/30 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-1-30
20 UNDERTAKER	ADDRESS 916
Dennis Carter	Bond

IMPORTANT. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 60989

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 60989

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Broadway Hosp ST. 1914 WARD)

2-FULL NAME Frank Sewell

(a) RESIDENCE NO 1625 Division ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha

6 DATE OF BIRTH (month, day, and year) 1891 Sept 25

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jas Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jane Sewell

(Address) 1625 Division

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Sudden

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) Augustus Hathaway M. D. Coroner

(Address) 1211 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL 10-1 1930

20 UNDERTAKER Hamel Corbett

ADDRESS 1930 5160

TION is very important See instructions on back of

1930 C. CAMPSON JONES, M.D.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 60990

CERTIFICATE OF DEATH.

E 60990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Eutaw Place ST. 11-24 WARD)

2-FULL NAME Mrs Anna Lewis Whiteley

(a) RESIDENCE NO. 1202 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Whiteley

6 DATE OF BIRTH (month, day, and year) Nov 12 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ Ind

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Georgetown (State or country) Delaware

PARENTS

10 NAME OF FATHER Arthur W. Milby

11 BIRTHPLACE OF FATHER (city or town) Milton (State or country) Delaware

12 MAIDEN NAME OF MOTHER Rebecca P. Lewis

13 BIRTHPLACE OF MOTHER (city or town) Upper Darby (State or country) Pennsylvania

14 Informant B. Albert Whiteley (Address) 1202 Eutaw Place

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30/30

17 I HEREBY CERTIFY, That I attended deceased from 2/19, 1930, to 9/29, 1930, that I last saw her alive on 9/29, 1930, and that death occurred, on the date stated above, at 2.20 A m.

The CAUSE OF DEATH* was as follows: Cerebral arteriosclerosis

(duration) Gradual yrs. mos ds.

CONTRIBUTORY (Secondary) Senile dementia

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

9/30, 1930 (Address) 1963 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederica Del.

DATE OF BURIAL Oct 2nd 1930

20 UNDERTAKER Henry N. Jenkins Sons

ADDRESS McCulloh & Orchard Sts

Spec.—1-30—M. & T.—250 Bks.

Time of burial extended to Oct. 1/30. J. Frederick Thompson Asst. Com'r of Health

E 60991 HEALTH DEPARTMENT—CITY OF BALTIMORE

194 E 60991

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 867 Linden Ave ST. 11-24 WARD)

2-FULL NAME Roberta Dessells

(a) RESIDENCE NO. 867 Linden Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex Co Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Matilda Graby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Cyndonia Waylee
(Address) 867 Linden Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1. 1930 to Sept 29. 1930.
that I last saw h[illegible] alive on 9/28 1930
and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows: Hart Thrombosis

(duration) ... yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Angina of age (duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Chiari, M. D.

9/30, 1930 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Virginia

20 UNDERTAKER Arnold J. Hawley

DATE OF BURIAL ... 19 ...

ADDRESS Middle

Spec.—1-30—M. & T.—250 Bks.

E 60992 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60992

CERTIFICATE OF DEATH.

REGISTERED NO. 1724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Meekins

(a) RESIDENCE NO. 54 Orchard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 1907

7 AGE: Years 21 | Months 3 | Days 25 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Meekins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lottie Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nellie Gaylord (Address) 534 Orchard St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1930, to Sept 29, 1930, that I last saw h[e/er] alive on Sept 29, 1930, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows: Appendicitis (Rupture) General Peritonitis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Lobar Pneum (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/25/30

Was there an autopsy? yes

What test confirmed diagnosis? Clinical — Operation

(Signed) B Harris M. D.

9/24, 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Oct 1 1930

ADDRESS 1701 Eutaw St

20 UNDERTAKER Samuel Hemsley

Spec.—1-30—M. & T.—250 Bks

E 60993 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60993

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3314 Kenyon Ave ST. 26-37 WARD)

2-FULL NAME Madeline Lorraine Shannon

(a) RESIDENCE No. 3314 Kenyon Ave ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 7 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant dd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edw. J. Shannon

11 BIRTHPLACE OF FATHER (city or town) New York (State or country)

12 MAIDEN NAME OF MOTHER Margaret Shannon

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Edw. J. Shannon
(Address) 3314 Kenyon ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/28 1930 to 10/1 1930, that I last saw her alive on 9/30 1930, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pertussis

Broncho pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —?

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. Finell M. D.

19 (Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL Oct. 3rd 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe

FILED OCT 1 1930 C. HAMPSON JONES, M.D. Registrar

Spec.—1-30—M. & T.—250 Bks

E 60994

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60994

31

CERTIFICATE OF DEATH.

REGISTERED NO. 26-40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3009 Shannon St. (Or WARD)

2-FULL NAME George W. Schmalzer

(a) RESIDENCE NO. 3009 Shannon Drive ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Emma V. Schmalzer

6 DATE OF BIRTH (month, day, and year) Aug 13 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrotyper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Electro Type Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Schmalzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Millard Schmalzer

(Address) 3009 Shannon Drive

15 Filed ....., 19 ..... E. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29-30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1930, to Sept. 29, 1930, that I last saw him alive on Sept. 29, 1930, and that death occurred, on the date stated above, at 11-50 P. m.

The CAUSE OF DEATH* was as follows:

2B. Pneumonia

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dave J. Feugler, M. D.

9/30, 1930 (Address) 2902 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Oct 2 1930

20 UNDERTAKER Frank V. Pipitone

ADDRESS 2818 E. Balto. St

Spec.—1-10-21—M&T—1500 Blks.

E 60995 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 848 N. Lombard St. 18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard N. Wingate.

(a) RESIDENCE NO. 848 N. Lombard St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hester Wingate

6 DATE OF BIRTH (month, day, and year): June 13 1860

7 AGE: Years 70 yrs. Months 3 Days 16 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sea Captain

(b) General nature of Industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bishop Head Md. Dorchester Co.

PARENTS

10 NAME OF FATHER: Bishop Wingate

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bishop Head Md.

12 MAIDEN NAME OF MOTHER: Lostlow Bramble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bishop Head Md.

14 Informant: Mrs. Anna Hampton

(Address) 848 N. Lombard St.

15 Filed 1-1930 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930. to Sept 29. 1930.

that I last saw h— alive on Sept 29. 1930.

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): none.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam.

(Signed) C. Hanson Jones, M. D.

11. 1930 (Address) 848 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md. DATE OF BURIAL: Oct 2 1930

20 UNDERTAKER: Curley & Codne. ADDRESS: 107 N. Howard St.

CAUSE OF DEATH. See instructions on back of certificate. THIS is very important.

Spec.—1-10-21—M&T—1500 Bks.

E 60996

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60996

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH Hamewood Apartments

CITY OF BALTIMORE: (No.) Charles & 31st ST. 12-50 WARD)

2-FULL NAME Frances Scott Brown Atkinson

(a) RESIDENCE NO. Charles & 31st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (HUSBAND) of (WIFE) of James Atkinson

6 DATE OF BIRTH (month, day, and year) Mar 3 - 1874

7 AGE Years 56 Months 6 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Fred Burwell Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary H. Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas Atkinson (Address) Charles & 31st Balto

15 Filed 9/30, 19 30 Registrar C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29/30 19

17 I HEREBY CERTIFY, That I attended deceased from Apl, 19 30, to Sep 29, 19 30.

that I last saw h[illegible] alive on Sep 29, 19 30.

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of R breast - axillary & supra - clavicular glands involved

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Apl

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) Fo Of Doctors, M. D.

9/30, 19 30 (Address) 5825 Yorkwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest DATE OF BURIAL 10/2 19 30

UNDERTAKER Thomas Lewis Garrison ADDRESS

Chas J. Evans Son 1180 West Royal Ave

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. ATION is very important.

OCT 1 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 60997

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 60997

CERTIFICATE OF DEATH

REGISTERED NO. 34

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 W. Lanvale ST.) (WARD) 46-12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Bradley

(a) RESIDENCE NO. 1310 W. Lanvale ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Allen Bromley

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Allen Bromley

(Address) 1310 W. Lanvale

15 Filed ....., 19.... C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 19.... to Sept. 27, 1930

that I last saw h.. alive on 26 Sept. 1930 at 4 A. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. 6 mos. 20 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/29/30 (Address) 1717 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ditchetts Va

DATE OF BURIAL Oct 1, 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Eutaw St

Important:

OCT 1 - 1930 C. HAMPSON JONES, M.D.

...—1-30—M. & T.—250 Bks.

E 60998 HEALTH DEPARTMENT—CITY OF BALTIMORE E 60998

CERTIFICATE OF DEATH.

REGISTERED NO. ....

1-PLACE OF DEATH In Jewish Hospital

CITY OF BALTIMORE: (No. Caroline St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Smith

(a) RESIDENCE NO. Fullerton ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 8 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of George C. Smith

6 DATE OF BIRTH (month, day, and year) Dec 6th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Klamanecia

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Maryland

14 Informant George C. Smith
(Address) Fullerton Md.

15 Filed ..., 19 ... Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 22 30, 19..., to Sept 30 30, 19..., that I last saw h She alive on Sept 30 30, 19..., and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

(duration) ... yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 9/26/30

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) C B Jones, M. D.

, 19 (Address) The Jewish Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Oct 3 30

UNDERTAKER Frank Lassahn Sons — ADDRESS 7401 Belair Rd

...—1-30—M. & T.—250 Bks.

E 60999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 60999

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2924 Keswick Road ST., 13-51 WARD)

2-FULL NAME Charles F. Shaeffer

(a) RESIDENCE NO. 2924 Keswick Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Emma L. Shaeffer

6 DATE OF BIRTH (month, day, and year) June 8-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	64	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 93

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pennsylvania Railroad

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua Shaeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Victoria Groag

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Grace Shaeffer (Address) 2924 Keswick Road

15 Filed 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1928, 19..., to Sept 28, 1930, that I last saw him alive on Sept 28, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chron. myocarditis

Ch. nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Hector Sto B M. D.

9/29 1930 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Oct 2 1930.

20 UNDERTAKER Horace F. Burgee

ADDRESS 3631 Falls Road.

1-29-28—L. F. S.—500 Bks. Clarence K. Hobbs

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 64000 E 64000

CERTIFICATE OF DEATH

113

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 Church ST. 25-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence K. Hobbs.

(a) RESIDENCE NO. 926 Church ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Infant.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

DATE OF BIRTH (month, day, and year) Feb. 26, 1930.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	2.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER William T. Hobbs.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Laurel Md.

12 MAIDEN NAME OF MOTHER Gertrude Bathgate.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hawkins Pt. Md.

14 Informant Mary A. Bathgate.
(Address) 926 Church St.

15 Filed 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30th - 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 11th, 1930, to Sept 30th, 1930.

that I last saw h... alive on Sept 29th, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia and enteritis

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY
(Secondary)
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? In place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Harry Leenhelt, M. D.

10/1, 1930 (Address) 1324-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Oct 2, 1930

20 UNDERTAKER H. Howard Evans ADDRESS 38 E. Fort Ave.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61001

REGISTERED NO. E 61001

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Fulton Ave Ward 45-41)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Elizabeth Melking

(a) RESIDENCE NO. 1412 Fulton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Charles E Melking

6 DATE OF BIRTH (month, day, and year): May 17-1854

7 AGE: Years 76 Months 4 Days 12

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Finksburg Carroll Co Md

10 NAME OF FATHER: Thos. Jackson Abbott

11 BIRTHPLACE OF FATHER (City or town) (State or country): Carrol Co. Md.

12 MAIDEN NAME OF MOTHER: Rebecca Elizabeth Stansburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co. Md.

PARENTS

14 Informant: William A. Melking

(Address) 3743 Clifton Ave

Registrar.

15 Filed. 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 29- 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 13 19 30 to September 29 19 30

that I last saw h~~er~~ alive on September 29 19 30

and that death occurred, on the date stated above, at 9.05 p m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ✓ yrs. 5 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George E Shannon M. D.

9/30 19 30 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arcadia Md.

Date of Burial: Oct 2 1930

20 UNDERTAKER: N. Bergman

ADDRESS: Pikesville Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

10-1930

Spec.—1-30—M. & T.—250 Bks

E 61002

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61002

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST., 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Smith

(a) RESIDENCE NO. 402 S. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-30

17 I HEREBY CERTIFY, That I attended deceased from 10-2-26, 19..., to 9-25-30, 19..., that I last saw h... im alive on 9-25-30, 19..., and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, cerebral;
Senile dementia

(duration) 4 yrs. mos da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 8 mos da.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

9-27, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITA

DATE OF BURIAL OCT 1 1930 19

20 UNDERTAKER

ADDRESS

Commissioner Health

Per Wm. E. [illegible]

TION is very important. See instructions on back of certificate.

1-20—M. & T.—100 B—50L

E 61003 ✓ E 61003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 29

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7-9 WARD)

2-FULL NAME Mildred Russell

(a) RESIDENCE No ..... ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred • yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Attendant
(b) General nature of industry, business, or establishment in which employed (or employer) ~~x0~~
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co., Md

PARENTS

10 NAME OF FATHER James Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Georgia Addison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records Baltimore, Md.
(Address)

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 30/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tetanus-Accidently run Splinter in heel 3 wks ago

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) J. H. Wallis, M. D.
Coroner

10/1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cem.	Oct 2 1930
20 UNDERTAKER Hoenluges & Son	ADDRESS Busen

CAUSE OF DEATH in plain terms, without abbreviations. See instructions on back of certificate.
TION is very important.

1550

1-30—M. & T.—100 B—50L

E 61004

HEALTH DEPARTMENT—CITY OF BALTIMORE

1/2 ✓

E 61004

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 821 S Rose ST., 1-3 (WARD)

2-FULL NAME Jacob Kabakowich

(a) RESIDENCE NO 821 S Rose ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kabakowicz

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Penn. R R
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER John Kabakowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jakla Backo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mary Kabakowicz

(Address) 821 S Rose St

15

Filed ..... 192 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

AC Tuberculosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) AC Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H C Glades, M. D. Coroner

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Russian Ind Cem — DATE OF BURIAL Oct 2 1930

20 UNDERTAKER John Griebhackas — ADDRESS 4238 Paca

Spec.—1-30—M. & T.—250 Bks.

E 61005 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61005

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310-N-Calvert ST. 12-50 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan C. Hamilton Caster

(a) RESIDENCE NO. 2310-N-Calvert ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hamilton Caster

6 DATE OF BIRTH (month, day, and year) Sept-5-1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Carlisle
(State or country) Penna.

PARENTS

10 NAME OF FATHER Henry Slicer

11 BIRTHPLACE OF FATHER (city or town) ? ?
(State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Elizabeth Roberts

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Robert Halliday (daughter)
(Address) 2310-N-Calvert Street

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M.D.

R.A.N.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Sept 30-1930,
that I last saw h[illegible] alive on Sept 29, 1930
and that death occurred, on the date stated above, at 9, A. m.
The CAUSE OF DEATH* was as follows:
Arterio Sclerosis —

(duration) Several yrs. ..... mos — ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —
If not at place of death? .....
Did an operation precede death? No — Date of .....
Was there an autopsy? No —
What test confirmed diagnosis? None —

(Signed) Chas W Lemmert M. D.
Sept 30 1930 (Address) 137 Park Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Oct 1 1930

20 UNDERTAKER Stewart & Mowen Company

ADDRESS 108 W. North Ave

ITION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61006 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61006

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST., 26-37 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Whinnan

(a) RESIDENCE NO. Balto. City Hosp. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	5	19	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster

(State or country) Pa.

PARENTS

10 NAME OF FATHER Richard

11 BIRTHPLACE OF FATHER (city or town) Pa.

(State or country)

12 MAIDEN NAME OF MOTHER Liza Weller

13 BIRTHPLACE OF MOTHER (city or town) Pa.

(State or country)

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M.D.

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-28-30

17 I HEREBY CERTIFY, That I attended deceased from 9-25-30, 19..., to 9-28-30, 19...,

that I last saw him alive on 9-28-30, 19...,

and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ...yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Almshouse; B.C.H.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Padget, M. D.

9-30, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul's Cem Oct

DATE OF BURIAL 2 19 30

20 UNDERTAKER John C. Miller 2436 E Monument

ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 61007 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61007

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., WARD) 1-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora (Mary) Tracey

(a) RESIDENCE NO. 266 S. Duncan st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Edgar Tracey

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Piwinski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Annie Byers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 7, 19 30, to Sept. 30, 19 30, that I last saw her alive on Sept. 30, 19 30, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Steiner, M. D.

9-30, 19 30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Harford Rd | DATE OF BURIAL Oct 3 1930

20 UNDERTAKER John M. Weber 411 N. Chester St | ADDRESS

TION is very important. See instructions on back of Certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61008 X 111 1001 E 61008

REGISTERED NO. 44324

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen. Hosp. ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry S. Cole

(a) RESIDENCE NO. Reisterstown, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
(or) WIFE of Mrs. Harry S. Cole

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butler, Md.

PARENTS

10 NAME OF FATHER Chas. E. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Pitts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital records.

(Address)

15 Filed [illegible], 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1930, to Oct. 2, 1930

that I last saw h[illegible] alive on Oct. 2, 1930

and that death occurred, on the date stated above, at 2 40 a. m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

Generalized Peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) Robert V. Canavitte, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Black Rock Cem.

DATE OF BURIAL 10/4 1930

20 UNDERTAKER H. C. Brooks & Son

ADDRESS [illegible] Md.

Spec.—1-30—M. & T.—250 Bks

E 61009 E 61009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4511 Park Heights Av ST., 45-5[illegible] WARD)

2-FULL NAME Harry John Steinecke

(a) RESIDENCE NO. 4511 Park Heights Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? [illegible] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Mrs Annie E Steinecke

6 DATE OF BIRTH (month, day, and year) Oct. 23 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager for Sh

(b) General nature of industry, business, or establishment in which employed (or employer) Ruppenstein Bros

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frederick Steinecke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Annie E. Steinecke
(Address) 4511 Park Heights Av

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30/30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1930, to Sept 30, 1930, that I last saw h[illegible] alive on Sept 30, 1930, and that death occurred, on the date stated above, at 6:20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Oesophagus Fourth Metastases.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? yes Date of Exploratory Lap July 1930

Was there an autopsy? no

What test confirmed diagnosis? Oesophagoscopy

(Signed) Nathaniel M Beck M. D.

10/1, 1930 (Address) 1002 E. 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Oct. 3 1930

20 UNDERTAKER Henry Stocke Sons, Inc. — ADDRESS 1301 E Eager St

2 OCT 1930 C. HAMPSON JONES, M.

Spec.—1-30—M. & T.—250 Bks

E 61010 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61010

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (NO. 15-21 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Sidney

(a) RESIDENCE NO. 1817 Cavanaugh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Sidney

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co. Va.

PARENTS

10 NAME OF FATHER Parker Sidney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Harriet Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 1930 C. HARRISON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-1-30

17 I HEREBY CERTIFY, That I attended deceased from 9-22-30, 19..., to 10-1-30, 19..., that I last saw him alive on 10-1-30, 19..., and that death occurred, on the date stated above, at 1:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) yrs. 5 mos da.

CONTRIBUTORY (Secondary) Auricular Flutter

(duration) yrs. mos. 18 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

10-1, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 10-4-30

20 UNDERTAKER Wm. H. Chrestoon

ADDRESS 1400 Madison

TION IS VERY IMPORTANT. SEE INSTRUCTIONS ON REVERSE SIDE

Spec.—1-30—M. & T.—250 Bks.

E 61011 E 61011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N East Ave ST. 26-11 WARD)

2-FULL NAME Susan Stump

(a) RESIDENCE NO. 13 N East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John C Stump

6 DATE OF BIRTH (month, day, and year) May 25 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas Flack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margaret Kullman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John C Stump (Address) 13 N East Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1, 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Oct 1, 1930, that I last saw h[illegible] alive on Sept 30, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) arterial Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Oct 2, 1930 (Address) 3100 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Oct 4 1930

20 UNDERTAKER John L Wilhide

ADDRESS 1008 Orleans

OCT 2 1930 C. HAMILTON JONES, M. D. RJK

Spec.—1-30—M. & T.—250 Bks.

E 61083
240843

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61012
118-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 14-20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Octavia Butler

(a) RESIDENCE NO. 1722 Druid Hill Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) of or (WIFE) of: William

6 DATE OF BIRTH (month, day, and year): Mch 25-1887

7 AGE — Years: 43 — Months: 6 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Heber Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harriet Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records
(Address): JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

9-1930 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept-29-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept-19, 1930 to Sept-29, 1930 that I last saw her alive on Sept-29, 1930 and that death occurred, on the date stated above, at 11 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Operation for Post-Operative Ventral Hernia

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes. Date of Sept 24, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. S. Everett, M. D.

9/30, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Thomas Cemetery — DATE OF BURIAL: 10/2/1930

20 UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS: 1631 Druid Hill Ave

1-30—M. & T.—100 B—50I.

E 61013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61013

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John England

(a) RESIDENCE NO 1228 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 6/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Moses England

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lillian England

(Address) 1228 Ashland Ave

15 Filed 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition-Gastro-intestinal Indigestion

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Gatens, M. D. Coroner

19 (Address) 306 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetry

DATE OF BURIAL oct 2 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E G1014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E G1014

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3007 Ellerslie St. 9-46 Ward)

2-FULL NAME George Nicholis Harrington

(a) RESIDENCE NO. 3007 Ellerslie ..St., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Harrington

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	55	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. F. & G. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Josiah Harrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER E. Bush.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Gerald Harrington
(Address) 3007 Ellerslie

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 19 30

17 I HEREBY CERTIFY, That I attended deceased from July 4, 19 30 to Oct 1, 19 30
that I last saw him alive on Oct 1, 19 30
and that death occurred, on the date stated above, at 12 midnight

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency & Cardiac Decompensation and Cerebrasa.

(duration) ... yrs. 2 mos 26 ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Chas. W. Edwards M. D.

, 19 (Address) 2746 Alameda Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	10-4 1930
20 UNDERTAKER L. J. Rauch	ADDRESS Lafayette

TION is very important. See instructions on back of Certificate.

OCT 2 1930 BALTIMORE, MD.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61015

CERTIFICATE OF DEATH.

74-001

E 61015

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2329 Edmondson St. 7 10-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Wright

(a) RESIDENCE No. 2329 Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of S Howard Wright

6 DATE OF BIRTH (month, day, and year) Sept 30, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Elbridge Buckingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Sarah Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant S H Wright

(Address) 2329 Edmondson Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30-30

17 I HEREBY CERTIFY, That I attended deceased from Apr 12, 1930, to Sept. 30, 1930, that I last saw h[illegible] alive on Sept. 29, 1930, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis. —

(duration) 4 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy (duration) yrs. mos. Sudden

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) M Bamberger M. D.

10/2, 1930 (Address) 2216 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Reisterstown Md. DATE OF BURIAL Oct 5 1930

20 UNDERTAKER George J Smith ADDRESS 1331 Hollins

HAMPSON JONES, M. D.

1-30—M. & T.—100 B—50L

E 61016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001

E 61016

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 W. Fayette ST. 19-27 WARD)

2-FULL NAME Unknown

(a) RESIDENCE NO 1700 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
40 Unknown			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant .....
(Address)

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Homicide - asphyxiation by illuminating gas

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. O'Brien, M. D.
Coroner

Sept 28 1930 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 2 1930
20 UNDERTAKER	**ADDRESS**
Edward Fowler	Wash Blvd

E 30 6 HAMPSON JONES M

Spec.—1-30—M. & T.—250 Bks

E 61017 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61017

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Sullivan

(a) RESIDENCE No. 1915 E. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 1. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph J. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ruth L. Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hospital Record

(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 1, 1930, that I last saw him alive on Oct 1, 1930, and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Premature Delivery

(5 months gestation)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical appearance

(Signed) G. Brues Alexander, M. D.

10/1, 1930 (Address) Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL NS HOPKINS HOSPITAL

DATE OF BURIAL OCT 2 1930 19

20 UNDERTAKER Commissioner Health.

ADDRESS

G. HAMILTON JONES, M.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61018 E 61018

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 E. 31st St. ST. 12-50 WARD).

2-FULL NAME Elizabeth Crow

(a) RESIDENCE NO. 416 E. 31st St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles E. Crow

6 DATE OF BIRTH (month, day, and year) Oct 12 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	9 11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Lemuel M. Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Clarence W. Bryan

(Address) 5127 Clarks Hill

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1930, to Oct 1—1930, that I last saw her alive on Oct 1—1930, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows: Hypertrophied ✓ Enlarged Heart.

(duration) 5 or more yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No. Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? ...

(Signed) W. E. Collins M. D.

, 19 (Address) 335 E. 21st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Oct 2, 1930

20 UNDERTAKER Chenowith Bros

ADDRESS 24 E. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61019 16-002 E 61019

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp ST. 8-A WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Roland Steiner

(a) RESIDENCE NO. 1164 N Bryant Ave ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6 1929

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Roland Steiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Emma Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Steiner

(Address) 1164 N Bryant Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1930, 19 ... to Oct. 1, 1930.

that I last saw h alive on Oct 1, 1930

and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Dysentery Infection

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Br. Pneumonia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Ashman, M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 10/3 1930

20 UNDERTAKER Fitzhugh Cole

ADDRESS 127 St Paul St

C. HAMILTON JONES, M.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61020 188-103 E 61020

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mt Ro Hosp Inst. E-45 Ward)

2-FULL NAME John A Nott

(a) RESIDENCE NO. 1721 Hanley Ave Ward

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella May Nott

6 DATE OF BIRTH (month, day, and year) Mar-17-1908

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	25	6	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) NRR Co
(c) Name of employer

9 BIRTHPLACE (city or town) Roland Md
(State or country)

PARENTS

10 NAME OF FATHER Geo C Nott

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Ella May Nott
(Address) 1721 Hanley ave.

15 Filed _____, 19 _____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
While riding a motorcycle collided with an auto
@

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Pulm. Edema

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Alameda & Fordham

Did an operation precede death? No Date of 10/1/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Inq

(Signed) J. Frank Hilton, M. D.

10/1/1930 (Address) 2939 N. Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Kwood Cemetery — DATE OF BURIAL 10/4 1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Entries must be complete and important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 61021 HEALTH DEPARTMENT—CITY OF BALTIMORE 001

CERTIFICATE OF DEATH. 100 E 61021

1-PLACE OF DEATH Hebrew Home for Incurables REGISTERED NO.

CITY OF BALTIMORE: (No. Green Spring Ave. Belvidere Ave. ST. 5-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Weinstein

(a) RESIDENCE NO. 2911 Violet Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (01) HUSBAND of (01) WIFE of: Sarah Weinstein

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 75 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: [illegible] Weinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: [illegible] —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Home (Address): 1431 Edmondson Ave

15 Filed ..., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1930

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1930, to October 1, 1930, that I last saw him alive on October 1, 1930, and that death occurred, on the date stated above, at 5 am pm

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of 10-1-30

Was there an autopsy? no

What test confirmed diagnosis? clinical test

(Signed) H Edmundheim, M. D.

, 19 (Address) Lemindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Cemetery DATE OF BURIAL: 10-3- 19 30

20 UNDERTAKER: Jacob Penn ADDRESS: 1431 Edmondson Ave

C. HARRY JONES, M. D.

Spec.—1-30—M. & T.—250 Bks

E 61022 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61022

123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Calvert 3 3rd st. ST., WARD)

2-FULL NAME Mrs. Harry Goldberg (Rose)

(a) RESIDENCE NO. 140 E. Clement ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Harry Goldberg.

6 DATE OF BIRTH (month, day, and year) Sept 4, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Moses Katzoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Annie Freeland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Goldberg. (Address) same.

15 Filed ..... 19 ..... Registrar RJK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/21, 1930, to 10/1/30, 19..., that I last saw her alive on 10/1/30, 19..., and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

~~Hemorrhage~~; Cholecystitis chronic, Cholelithiasis (Common duct stone) (duration) 3 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) ~~Cholelithiasis~~ Hemorrhage, post-op. shock (duration) ½ yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of 10/1/30

Was there an autopsy? No.

What test confirmed diagnosis? Operative findings

(Signed) Samuel McLanahan, M. D.

Oct. 1 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howe Wash. Road — DATE OF BURIAL 10-3- 19 30

20 UNDERTAKER — ADDRESS

Max Levin, 1429 Edmondson Ave.

Spec.—1-30—M. & T.—250 Bks.

E 61023 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61023

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 N. Broadway ST., 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Gudeman

(a) RESIDENCE NO. 1509 N Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Emma Gudeman

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer 36

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Abraham Gudeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Rebecca —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Mrs Gudeman (daughter)

(Address) 1509 N. Broadway

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ~~Sept~~ Oct. 2/30

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to Oct 2, 1930,

that I last saw h alive on Oct 2, 1930,

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray, stool exam. history

(Signed) Paul Cohen, M. D.

10 2, 1930 (Address) 2 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monument Ave Road

DATE OF BURIAL 10-3- 1930

20 UNDERTAKER D. Tice Funeral, 1431

ADDRESS E Balt St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61024

CERTIFICATE OF DEATH

188-103 E 61024

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. John Hopkins Hosp St., 5-4 Ward)

2-FULL NAME Mary E Nash

(a) RESIDENCE NO. 1406 Fairmount St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Col	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or... min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer

9 BIRTHPLACE (city or town) Petersburg
(State or country) Va

PARENTS

10 NAME OF FATHER Simon Carey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not known

14 Informant John Hopkins Hosp
(Address) 1214 E Fairmount ave

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30 1930

17 I HEREBY CERTIFY, That I took charge of the remains deserihed above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by moving auto & walking into side of it

@ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Hem
Fract R. Femur (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Taylor & Spring

Did an operation precede death? no Date of

Was there an autopsy? Yes Clinical & Path.

What test confirmed diagnosis?

(Signed) J. Fraser M. D.

10 2, 1930 (Address) 24 24 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern cemetery

DATE OF BURIAL oct 3 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1681 orleans st

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61025

100-001 E 61025

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 E. Chase ST. 10-14 WARD)

2-FULL NAME Mayette L. Neuschafer

(a) RESIDENCE NO. 725 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? Sup yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 31 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER John C. Neuschafer

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Mary J. Kennedy

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant (Address) Mrs Mary J. Neuschafer 725 E Chase St

15 Filed ....., 19 ..... Registrar

C. BRANSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1930, to Oct 1, 1930, that I last saw her alive on Oct 3 19..., and that death occurred, on the date stated above, at 3.25 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobular Pneumonia

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hamilton, M. D.

10/2, 1930 (Address) 733 Augusta Rt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Oct. 4 1930

20 UNDERTAKER Henry Hoeck Sons, Inc.

ADDRESS 1301 E Eager St

30—M. & T.—100 B—50L

Mary Preller

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61026

40

REGISTERED NO. E 61026

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 N. Caroline ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Preller

(a) RESIDENCE NO 1534 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George, Preller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Dorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Catherine Preller

(Address) 1534 E. Caroline St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Stuart Collins, M. D. Coroner

10/31, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Oct 4 1930

20 UNDERTAKER Henry Stolcke & Sons Inc

ADDRESS 1301 E Eager St

RCK

30—M. & T.—190 B—50L

61027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 74091 E 61027

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital ST. 14th (WARD)

2-FULL NAME Lillian C. Bauer

(a) RESIDENCE NO. 1827 W. Balto ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29, 1883

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	11	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer): 367
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Theo H Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Anna Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Miss Mary B. Bauer
(Address) 1827 W. Balto St.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible], M. D. Coroner

Oct 2 1930 (Address) 1 Brooklyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Cathedral — DATE OF BURIAL: Oct 4 1930

20 UNDERTAKER: Jos C. Farley — ADDRESS: 1809 W Fayette

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61028

90 E 61028

CERTIFICATE OF DEATH

REGISTERED NO. 125-12

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1800 Letitia Ave. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine A Wolf

(a) RESIDENCE NO. 1800 Letitia Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 - 1847

7 AGE: Years 83; Months 4; Days 29; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Laila R Schmidt

(Address) 1800 Letitia Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to Oct. 1, 1930.

that I last saw h alive on Sept. 30, 1930

and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

acute cardiac dilatation

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) chronic myocarditis and senile arterioscleros (duration) over 7 yrs. 7 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Thos. E. Cole M. D.

10/2 1930 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Oct 4 1930

20 UNDERTAKER: J. J. McCully

ADDRESS: 128 E Lent Ave

Spec.—1-30—M. & T.—250 Bks.

E 61029

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61029

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 16-67

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Dotart

(a) RESIDENCE NO. 3004 Grayson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60?	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer) ? $6

(c) Name of employer ?

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

14 Informant Coroner's Inquest
(Address) Baltimore City Hospitals

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-30-30

17 I HEREBY CERTIFY, That I attended deceased from 9-7-, 1930, to 9-30-, 1930, that I last saw him alive on 9-30, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical findings

(Signed) Fred M. Dudderar, M. D.

9/y, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL 10/4 1930

20 UNDERTAKER John J. Connelly Essex

ADDRESS

Spec. 1-30—M. & T.—250 Bks.

61030

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61030

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. 73-34

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patricia Goodrich

(a) RESIDENCE NO. 15-16 Oakford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ellsworth Goodrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Olive Flanigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ellsworth Goodrich

(Address) 1516 Biscayne Av

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-2-30

17 I HEREBY CERTIFY, That I attended deceased from 9-28-30, 19..... to 10-2-, 19 30,

that I last saw h alive on 10-2-30, 19.....,

and that death occurred, on the date stated above, at 11.25 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) Lawrence Sisera, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Oct. 4 1930

20 UNDERTAKER Margaret E. Flynn — ADDRESS 1422 Light St.

Cor.—10-10-20—A.O.—5120 Blks.

E 61031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 61031

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Rochambeau Apartments. Charles & Franklin Sts. St. 11-25 Ward)

2-FULL NAME Ellenore Dutcher Key.

(a) RESIDENCE NO. Rochambeau Apartments. Charles & Franklin Sts. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced XXXXXXXXXX (or) WIFE of John Ross Key.

6 DATE OF BIRTH (month, day, and year) August 15, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	68	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Omaha, Nebraska.
(State or country)

PARENTS

10 NAME OF FATHER Rodney B. Dutcher.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Columbus, Ohio.

12 MAIDEN NAME OF MOTHER Margaret E. Johnson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Norway.

14 Informant A. J. Dutcher. (brother)
(Address) 1328 Berge Ave. Chicago, Ill.

15 Filed ... 19... ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardiat Insufficiency.
Acute dilatation of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry?

(Signed) Otto M. Reinhardt, M. D.

10/3 1930 (Address) 1010 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md. DATE OF BURIAL Oct 4 1930

20 UNDERTAKER Stewart & Mowen Co. ADDRESS 105 W North ave

Important. See instructions on back of certificate.

OCT 4 1930 HAMPSON JONES, M.

Spec.—8-16-29—L. F. S.—100 Bks.

E 61032

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61032

CERTIFICATE OF DEATH

REGISTERED NO. 122

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 East Read ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine T. Nunan

(a) RESIDENCE NO. 6 East Read ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. - mos. - ds. How long in U. S., if foreign birth? - - yrs. - - mos. - - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) -------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Andrew G. Nunan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Dailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant J. Nunan McFee

(Address) 429 Kenneth Square

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Oct. 2, 1930, that I last saw h.. alive on Oct. 2, 1930, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis, Cerebri

2 Years (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema + Myocarditis (duration) yrs. 2 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friedenwald, M. D.

, 19 (Address) 1013 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 10/4 19 30

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61033

CERTIFICATE OF DEATH.

3/ E 61033

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 16-22

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Ladson

(a) RESIDENCE NO. 613 N. Mount st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Letty Ladson

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 0 4 0

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Goosecreek, (State or country) South Carolina

PARENTS

10 NAME OF FATHER Richard Ladson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to Oct. 2, 1930, that I last saw him alive on Oct. 2, 1930, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis, acute

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) David Jenner, M. D.

10-2, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charleston, South Carolina

DATE OF BURIAL Oct 4, 1930

ADDRESS 3228 Schroeder St

20 UNDERTAKER Mrs Katie R Williams

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61034

CERTIFICATE OF DEATH.

1928 129 E 61034

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves ST. 19th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Yeager

(a) RESIDENCE NO. 1709 Lemmon ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 56 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Thomas Devereaux

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Aspel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Frame Cook

(Address): 1703 Lemmon St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-2 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-5, 1930, to 10-2, 1930, that I last saw her alive on 10-2, 1930, and that death occurred, on the date stated above, at 6.40 9 m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal dis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical diagnosis & findings

(Signed) Helmar S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem

DATE OF BURIAL: Oct 4th 1930

20 UNDERTAKER: A Jones

ADDRESS: 111 S Gilmor

C. HAMPSON JONES, M. D.

REGISTRAR

OCT 3 1930

THIS is very important. See instructions on

Spec.—1-12-23—M&T—500 Blks.

E 61035

HEALTH DEPARTMENT—CITY OF BALTIMORE

94-001

94 E 61035

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1833 W. Vine st. (St.) (Ward) 20-27

2-FULL NAME James Albert Broner Jr.

(a) RESIDENCE NO. 1833 Vine st. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 24, 1929

7 AGE — Years: 1 — Months: 4 3 — Days: 7 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Jas. Albert Broner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Nora L. Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant (Address): Nora L. Broner 1833 vine st.

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1st, 30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1930, to Oct. 1st. 1930

that I last saw him alive on Oct. 1st. 1930

and that death occurred, on the date stated above, at 9.45 p.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Acct Bronchitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

. 19 (Address) 1631 W. Franklin st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Oct 4 1930

20 UNDERTAKER: A. Jones

ADDRESS: 111 S Gilm

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61036

CERTIFICATE OF DEATH.

129 E 61036

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 346 W. Biddle ST. 11-24 (WARD)

2-FULL NAME Mose Rogers

(a) RESIDENCE NO. 346 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	C.	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ellen Rodgers

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt 93			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Veteran

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Hans Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sylvania Bowling (Address) 346 W. Biddle St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1930, to Sept 30, 1930, that I last saw him alive on Sept 29, 1930, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) none (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. K. Petersen, M. D.

, 19 (Address) 17 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodland

DATE OF BURIAL Oct 3 1930

ADDRESS 1725 Eutaw

20 UNDERTAKER Wm. R. G. Elliott

Spec.—1-30—M. & T.—250 Bks.

E 61037

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 001
10 E 61037

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 W 27 St ST. 12-51 WARD)

2-FULL NAME Mary A Shields

(a) RESIDENCE NO. 1 W 27 St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Baker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Kerr

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs E Nelson
(Address) 1 W 27 St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1920 to Oct. 2, 1930,
that I last saw h[illegible] alive on Oct 2, 1930,
and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac
Dilatation
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) F D Handley M. D.

, 19 (Address) 2512 Maryland Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cemetery Long Green

DATE OF BURIAL Oct 4 1930

20 UNDERTAKER J Vernon Kuhner

ADDRESS Hollins

1-30—M. & T.—100 B—50L

61038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24 001 E 61038

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1901 Ellamont St. 15-67 WARD

2-FULL NAME James A. Serre

(a) RESIDENCE NO. 1901 Ellamont St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Annie Sampey
(Address) 1514 Moreland Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1930.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) H. Leslie Diggs, M. D. Coroner

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 3 1930

20 UNDERTAKER H. Turnbull & Bro

ADDRESS 1127 E Balto st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61039 ✓ 46 E 61039

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Penna Ave ST. 14-20 WARD)

2-FULL NAME Mary Carter

(a) RESIDENCE NO. 1922 Penna Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1851 Unknown

7 AGE: Years 79; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Celia Wells (Address): 1922 Penna Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1930, to Oct 2, 1930, that I last saw h[illegible] alive on Oct 1, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

10-2, 1930 (Address) 1428 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 10-5 1930

20 UNDERTAKER: Sam'l W. Chase & Son

ADDRESS: 1420 Madison

TION is very important. See instructions on reverse side.

OCT 3 1930 C. H. [illegible] JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

61040

E 61040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 Edmondson Ave STATE 16 WARD 46)

2-FULL NAME Emma E. Bayly (or Temporary No.)

(a) RESIDENCE No. ~~2306~~ ~~Edmondson Ave~~ ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Late Hamilton B. Bayly

6 DATE OF BIRTH (month, day, and year): Aug 3 1860

7 AGE: Years 70 Months 2 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cato

PARENTS

10 NAME OF FATHER: Andrew Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger

14 Informant: Julius Thurm Jones. (Address) 2306 Edmondson Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Oct 2, 1930, that I last saw h-er alive on Oct 1, 1930, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH was as follows:

Cerebral hemorrhage.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

10/2/1930 (Signed) Bernard F. Trenti, M. D.

(Address) 2329 Arunah Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem DATE OF BURIAL 10/4 1930

20 UNDERTAKER: Philip Herwig 2016 ADDRESS Oldean

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61041

E 61041

CERTIFICATE OF DEATH.

117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital 10-1 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Viola ~~W~~ Wilger

(a) RESIDENCE NO. 421 London Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank S. Wilger

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Kegg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Suter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Samuel Dean (Address) 421 London ave

15 Filed 3 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 1 1930.

17 I HEREBY CERTIFY, That I attended deceased from 9-28, 1930, to 10-1, 1930.

that I last saw h~~er~~ alive on 10-1, 1930.

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? appendectomy

Did an operation precede death? Yes Date of 9/28/30 -

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Robt Beven, M. D.

10/1, 1930 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Park Cemetery

DATE OF BURIAL Oct. 4, 1930.

20 UNDERTAKER John A. Denny

ADDRESS 715 Light St

TION is very important. See that every

Spec.—9-30—A. & Co.—250 Bks.

E 61042 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 162 E 61042

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 9-46 WARD)

2-FULL NAME Baby Warder

(a) RESIDENCE NO. 1625 Abbotson ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25-30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 40 min.
	—	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — 00
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER William Meekling
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Lillian Warder
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26/30.

17 I HEREBY CERTIFY, That I attended deceased from 9-25-, 1930, to 9-26-, 1930
that I last saw him alive on 9-26-, 1930.
and that death occurred, on the date stated above, at 1.00 a. m.
The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY — (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? Yes.
What test confirmed diagnosis?
(Signed) E. A. Harris, Jr. M. D.
19 ..... (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or if deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL OCT 3 1930 19

20 UNDERTAKER Undertaker Health ADDRESS
By: [illegible]

Spec.—0-30—A. & Co.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

61043 ✓ 161-A 61043

CERTIFICATE OF DEATH.

1. PLACE OF DEATH Johns Hopkins Hospital. 6-9

CITY OF BALTIMORE: (No ..... St ..... Ward) II

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Baby Rothhaupt

(a) RESIDENCE No. 408 N. Chester St. ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28/30.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	—	6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Rothhaupt

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Annie Barnhart

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant (Address) Johns Hopkins Hospital.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29, 30

17

I HEREBY CERTIFY, That I attended deceased from 9-28-, 1930, to 9-29-, 1930

that I last saw h er alive on 9-29-, 1930.

and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ~
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of ~

Was there an autopsy? Yes.

What test confirmed diagnosis? ~

(Signed) E. W. Harrison, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL (CREMATION OR REMOVAL) JOHNS HOPKINS HOSPITAL — DATE OF BURIAL OCT 3 1930, 19

20 UNDERTAKER C. D. Ellsworth — ADDRESS

Commissioner of Health

Per Wm. E. Woodall

Spec.—9-30—A. & Co.—250 Blks

61044 HEALTH DEPARTMENT—CITY OF BALTIMORE 1625 61044

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
CITY OF BALTIMORE: (No 227 N. Gallas ST. 6-9 WARD)
2. FULL NAME Baby Simon (1)
(a) RESIDENCE NO. 227 N. Gallas ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Black | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15/30
7 AGE Years | Months | Days | If LESS than 1 day, 10 hrs. or 30 min.

8 OCCUPATION OF DECEASED —
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Herman Simon
11 BIRTHPLACE OF FATHER (city or town) Darlington
(State or country) South Carolina
12 MAIDEN NAME OF MOTHER Elma White
13 BIRTHPLACE OF MOTHER (city or town) Darlington
(State or country) South Carolina

14 Informant
(Address) Johns Hopkins Hospital

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15-16, 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-15-, 1930, to 8-15-, 1930.
that I last saw her alive on 8-15-, 1930.
and that death occurred, on the date stated above, at 3:58 P m.
The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? yes
What test confirmed diagnosis? —
(Signed) Elliott Harrison M. D.
(Address) Johns Hopkins Hospital.
, 19

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL
DATE OF BURIAL 19
ADDRESS

20 UNDERTAKER JOHNS HOPKINS HOSPITAL
ADDRESS W. W. H. WOODALL

OCT 3 1930

Spec.—9-30—A. & Co.—250 Rks

E 61045

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61045

162

CERTIFICATE OF DEATH

6-9

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 227 N. Dallas ST. ..WARD)

2 FULL NAME Baby Simon (II)

(a) RESIDENCE NO. 227 N. Dallas ST., ..WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..yrs. ..mos. ..ds. How long in U. S., if of foreign birth? ..yrs. ..mos. ..ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15/30.

7 AGE	Years	Months	Days	If LESS than 1 day 13 hrs. or 30 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Forman Simon

11 BIRTHPLACE OF FATHER (city or town) Darlington (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Elma White

13 BIRTHPLACE OF MOTHER (city or town) Darlington (State or country) South Carolina

14 Informant (Address) Johns Hopkins Hospital

15 Filed ..., 19.., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15-24/1930.

17 I HEREBY CERTIFY, That I attended deceased from 8-15-, 1930, to 8-15-, 1930.

that I last saw h in alive on 8-15-, 1930.

and that death occurred, on the date stated above, at 7.00 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY —
(Secondary)
(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) C. H. Harrison M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hospital

DATE OF BURIAL OCT 3 1930 19

20 UNDERTAKER Par. Wm. B. Woodall

ADDRESS

C. HAMPSON Jones, M. D.

Registrar

Cor.—10-10-29—A Co.—100 Bks.

E 61046

HEALTH DEPARTMENT—CITY OF BALTIMORE

166 E 61046

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (a) Mercy Memorial Hospital St., 4-41 Ward

2-FULL NAME Esther Leopold Ault

(a) RESIDENCE NO. 609-E-37th St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mr. Elmer Ault

6 DATE OF BIRTH (month, day, and year) April 26-1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35	5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Tennessee

PARENTS

10 NAME OF FATHER ? Leopold.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Francis Baker

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Penna.

14 Informant Mr. Elmer Ault
(Address) 609 E. 37th St.

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acchlorhydria
Sprue

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

10-3 1930 (Address) 163 E. Pleasant

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem.

DATE OF BURIAL Oct 5 1930

20 UNDERTAKER Geo. W. Little

ADDRESS 42 E. Lanvale St.

C. HAMPSON JONES, M. D.

3-1930

Regt

Spec.—1-30—M. & T.—250 Bks.

E 61047 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61047

CERTIFICATE OF DEATH.

64

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3607 Harlem ave ST. 20-67 WARD)

2-FULL NAME Margaret A Pfeffer

(a) RESIDENCE NO. 3607 Harlem ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: widow of Jos. H. Pfeffer

6 DATE OF BIRTH (month, day, and year): April 14 1849

7 AGE — Years: 81 Months: 5 Days: 19 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER: Daniel Shaffner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Mary Linch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsa

14 Informant: Mrs Beulah Margaret Butler (Address) 3607 Harlem ave Balto

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/3/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22 1930 to Oct. 3rd 1930, that I last saw her alive on October 2 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Senility, failing for several yrs.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Unable to swallow

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) C A Smith, M. D.

10/3 1930 (Address) 1605 N. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Luthern Cemetery Reisterstown — DATE OF BURIAL: Oct 6 1930

20 UNDERTAKER: J. F. Ebert — ADDRESS: Reisterstown Md

HAMPSON JONES, M. D.

Spec. 2-29-28—L. F. S.—500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61048 ✓ E 61048

CERTIFICATE OF DEATH

07-54-43

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5507 Jonquil Ave. ST. WARD)

2—FULL NAME Henry N. Kilman

(a) RESIDENCE NO. 5507 Jonquil Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Susan Richardson Kilman

7 DATE OF BIRTH (month, day, and year) Aug. 2, 1851

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Real Estate Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Maryland

10 NAME OF FATHER Nicholas Kilman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Maryland

12 MAIDEN NAME OF MOTHER Sarah Whitney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Maryland

PARENTS

14 Informant Mr. Harry N. Kilman
(Address) 3608 Yolando Road

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1930

17 I DEREBY CERTIFY, That I attended deceased from March 1st, 1930, to Oct 2nd, 1930, that I last saw h in alive on Oct. 1st, 1930 and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Epithelioma of mouth. (Cadcer)
Chronic cystitis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Hypertrophied prostate.
(duration) 0 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sym & symptoms

(Signed) J. A. Chatard, M. D.

Oct 2nd, 1930 (Address) 300 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Oct. 4 1930

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore, Md.

C. HAMPSON JONES, M. D.
3-1930

Cor.—12-9-25—A Co.—200 Bks.

E 61049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 61049

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 421 Massachusetts St., 28 Ward)

2-FULL NAME George L. Omeggs.

(a) RESIDENCE NO. 421 Massachusetts Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Matilda Omeggs

6 DATE OF BIRTH (month, day, and year): January 5th 1859

7 AGE: Years 71 Months 8 Days 8 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Edward Omeggs.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Pauline Cook

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs. Matilda Omeggs.

(Address) 421 Mass. Ave.

15 Filed Oct 6 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Injury

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Theodore Brooke M. D.

(Coroner)

Oct 3 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Oct 6 1930

20 UNDERTAKER Joel H. Cook ADDRESS 1003 N. Eutaw St.

Spec.—1-30—M. & T.—250 Bks.

E 61050

1-10683
E.61050

HEALTH DEPARTMENT—CITY OF BALTIMORE

+122-001

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Anthony Neely

(a) RESIDENCE NO. Ring 29 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Havana Cuba yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Concepcion

6 DATE OF BIRTH (month, day, and year) 1-19-76

7 AGE: Years 54 | Months 9 8 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary M

(b) General nature of industry, business, or establishment in which employed (or employer) Havana

(c) Name of employer Elec R.R. Co

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Louis Neely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ia

12 MAIDEN NAME OF MOTHER Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19..... Registrar .....

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1930

17 I HEREBY CERTIFY, That I attended deceased from 9 14, 1930, to 10 2, 1930, that I last saw h[illegible] alive on 10 2, 1930, and that death occurred, on the date stated above, at 3-50 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Cuba.

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) C. H. Fisher, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Park N.J.

DATE OF BURIAL Oct 3 1930

20 UNDERTAKER John D. Whitehead Sons

ADDRESS (Place) 1900 Eutaw

1-30—M. & T.—100 B—50L

E 61051

Mary A. Eccleston ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

52 E 61051

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2305 E. Federal ST. 8-16 WARD)

2-FULL NAME Mary A. Eccleston

(a) RESIDENCE NO 2305 E. Federal ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of Geo A. Eccleston
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 6/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	75	0	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Despeaux

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Dore

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed ..... , 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

Senility

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John H. Collins, M. D.
Coroner

, 19 (Address) 2305 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetary

DATE OF BURIAL 10/4/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul st

Spec.—1-30—M. & T.—250 Bks. Dr Keller 222 W. Monument St Ver 4829 7to8

E 61052 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61052

49

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 1803 Linden Ave (WARD) 17-51

2-FULL NAME Annie M. Charchea

(a) RESIDENCE NO. 2606 Maryland Ave WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of or) WIFE of: Thos A Charchea

6 DATE OF BIRTH (month, day, and year): June 16th 1857

7 AGE: Years 73 | Months 3 | Days 17 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: Frederick ———
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Arthur V. Charchea
(Address) 334 E. University Pkwy

15 Filed _____ 19 _____ Registrar
Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from August 9- 1930, to Oct 3 1930,
that I last saw h[illegible] alive on Oct 2- 1930,
and that death occurred, on the date stated above, at 12.15A m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Pancreas
(duration) 2 yrs. — mos — ds.
CONTRIBUTORY (Secondary) none known (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Md
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical
(Signed) Chas. J Keller M. D.
10/3, 1930 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery
DATE OF BURIAL: 10/4/1930

20 UNDERTAKER: Wm Cook
ADDRESS: 1217 St Paul St

1930 C. HAMPSON JONES, M. D.

0—M. & T.—100 B—50L

E 61053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-001 E 61053

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST. 8-13 WARD)

2-FULL NAME Warren Charles Ferguson

(a) RESIDENCE NO 1209 Rutland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine Ferguson

DATE OF BIRTH (month, day, and year) Mar 19/1888

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	6	12	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer H. W. Jenkins Sons Co.

BIRTHPLACE (city or town) (State or country) Wilmington, Del.

PARENTS

10 NAME OF FATHER Joseph Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sophie ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Katherine Ferguson

(Address) 1209 Rutland Ave

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Arterial Occlusion (Cardiac Arteriosclerosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? YES

What test confirmed diagnosis? .....

(Signed) J. H. Calvin, M. D. Coroner

10/2/30, 19 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Oct 4 1930

20 UNDERTAKER Henry W. Jenkins & Co

ADDRESS Eutaw & Lexington

pec.—1-30—M. & T.—250 Bks.

E 61054 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61054

CERTIFICATE OF DEATH.

REGISTERED NO. 21-29 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lusby

(a) RESIDENCE NO. 1016 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

3a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Febry 12th - 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles F Lusby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Marie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs C F or J Lusby

(Address) 1016 W Cross St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1930, to Oct. 3, 1930, that I last saw him alive on Oct. 3, 1930, and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
Type undetermined

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diarhea & Enteritis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? 1016 W. Cross St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lucky Robert Cohen M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL 10/6/1930

20 UNDERTAKER Robert J Cowan & Son

ADDRESS 701 Cathedral St.

Spec.—1-12 23—M&T—500 Bks.

E 61055

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61055

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3450 Smallwood ST.) 90-64 (WARD)

2-FULL NAME Ferdinand Ernst Landel

(a) RESIDENCE NO. 345 S. Smallwood ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 - 1887

7 AGE Years 43 Months 4 Days 22 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Self 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Ernest Landel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Zinkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Elizabeth Richter (Address) 345 S. Smallwood St.

15 Filed ..... , 19 ..... Registrar A. O. H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/5 , 1930 , to 10/2 , 1930 , that I last saw him alive on 10/2 , 1930 , and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Klopfer, M. D.

, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Oct. 6 1930

20 UNDERTAKER George L. Stewart

ADDRESS 1101 Eutaw Ave.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

E 61056

CERTIFICATE OF DEATH.

E 61056

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 4017 Walbrook Ave (Ward) 20-21

2-FULL NAME Martha E. Petersen

(a) RESIDENCE NO. 4017 Walbrook Ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	26	03	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md

(State or country)

PARENTS

10 NAME OF FATHER Carl Petersen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Denmark

12 MAIDEN NAME OF MOTHER Camilla Vogelsang

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Camilla Petersen

(Address) 4017 Walbrook Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1930, to Oct 2 1930, that I last saw her alive on Oct 2 1930, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Unascertained

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted —

If not at place of death!

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? clinical signs

(Signed) A. L. R. Lucia, M. D.

Oct. 23 1930 (Address) 3921 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial: Oct. 4th 1930

20 UNDERTAKER: George L. Schwab — ADDRESS: 2101 Fulton Ave

very important. See instructions on back of certificate.

pec.—1-30—M. & T.—250 Bks

E 61057 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61057

CERTIFICATE OF DEATH.

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 917 Hanover St. (Ward) 23-31

2-FULL NAME James Horsey Jr

(a) RESIDENCE NO. 917 Hanover St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 29-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	4	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (City or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Horsey Sr.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Carrie Fisher

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto. Md.

14 Informant Mary A. Goldsborough (Address) 917 Hanover St.

15 Filed, ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1930, to Oct. 3, 1930, that I last saw h/M alive on Oct. 3, 1930, and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

10/3, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct 4 1930

ADDRESS 14 W Lexington St

20 UNDERTAKER Marzolf & Hyman

C. HAMPSON JONES, M.D.

pec.—1-30—M. & T.—250 Blks

E 61058

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61058

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 18-W ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Maxfield.

(a) RESIDENCE NO. 1012 Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ronalds (Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1923, to Sept 29, 1930.

that I last saw her alive on Sept 29, 1930

and that death occurred, on the date stated above, at 7.00 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis more than (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget M. D.

10-2, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Oct 4 1930

20 UNDERTAKER Samuel Hensley & Bro

ADDRESS

...ec.—1-30—M. & T.—250 Blks.

E 61059 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61059

CERTIFICATE OF DEATH.

90

REGISTERED NO. 15-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. WARD

2-FULL NAME Thomas A. Berney

(a) RESIDENCE NO. 3909 Boarman Ave ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Florence M. Berney

6 DATE OF BIRTH (month, day, and year) Jan 16 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector 086

(b) General nature of industry, business, or establishment in which employed (or employer) Racing

(c) Name of employer Common

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Berney

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Cleary

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Florence M. Berney
(Address) 3909 Boarman Ave

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-2-30

17 I HEREBY CERTIFY, That I attended deceased from 9-25, 19 30, to 10-2, 19 30, that I last saw h.. alive on 10-2, 19 30, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Lawrence M. Lesh, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Oct 6th 30

20 UNDERTAKER F. A. Krauseson

ADDRESS 703 Hamp...

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61060

CERTIFICATE OF DEATH

1292 61060

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 N. Lakewood Ave. ST., 9-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME JOHN LASSEN

(a) RESIDENCE NO. 613 N. Lakewood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth 80 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Philipina Lassen

DATE OF BIRTH (month, day, and year) July 6, 1847

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	33	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 4 years

(c) Name of employer Stewart & Co.

BIRTHPLACE (city or town) (State or country) Denmark

10 NAME OF FATHER John Lassen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Johanna Brinck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant Mrs. Philipina Lassen (Wife)

(Address) 613 N. Lakewood Avenue.

15 Filed ..... 19 ..... Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 22, 1930, that I last saw h. him alive on Oct 1, 1930.

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism - Anginal attack

Cardio - vas culer - renal disease.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Hypertension -

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? urinal thy. exam.

(Signed) Louis F. Kemmerer, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Oct. 5 1930
20 UNDERTAKER	ADDRESS
Henry Sander & Sons. Inc.	Baltimore St & Broadway.

pec.—1-30—M. & T.—250 Bks.

E 61061 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61061

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. 8-16 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nanie McQuay

(a) RESIDENCE NO. 2696 E. Oliver ST., WARD Tilghmans Island Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE — Years: 62 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Talbot Co Md.

PARENTS

10 NAME OF FATHER: John Canning

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harriet Brunnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Eslina Falkner Tilghman Island Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1930, to Oct. 3, 1930,

that I last saw her alive on Oct. 3, 1930,

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

General cerebral arteriosclerosis (duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 3 days yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Milton Bikrsh, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tilghman Island Md — DATE OF BURIAL: 10/8 1930

20 UNDERTAKER: W E Gosson — ADDRESS: 841 W 37th St.

pec.—1-30—M. & T.—250 Bks

E 61062

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61062

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3405 Dupont Ave ST. 27-E WARD)

2-FULL NAME Lillie May Gearden

(a) RESIDENCE NO. 3405 Dupont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced (~~HUSBAND~~ of (or) WIFE of: Wm O. Gearden

6 DATE OF BIRTH (month, day, and year): June 19-1885

7 AGE — Years: 45 — Months: 3 — Days: 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jo William Garner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Laura A Ways

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Wm O. Gearden

(Address): 3405 Dupont Ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 2-1930

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to Oct. 2, 1930,

that I last saw h~~er~~ alive on Oct 1, 1930,

and that death occurred, on the date stated above, at 9-45 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Myocardial Insuff

Hypertension

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? P. E. & Lab.

(Signed) Homer U. Dodge, M. D.

10/3, 1930 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem.

DATE OF BURIAL: Oct 6 1930

20 UNDERTAKER: Harry W. Ehlen

ADDRESS: 1944 W. Norden

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61063

186-103 E 61063

CERTIFICATE OF DEATH

16-79

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., [illegible] Ward)

2-FULL NAME William P. Durkin

(a) RESIDENCE NO. 920 West Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma C. Lafferty Durkin

6 DATE OF BIRTH (month, day, and year) January 1, 1898

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
32	9	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teamster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mr James Flannery

9 BIRTHPLACE (city or town) _____
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael Durkin

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Ireland

14 Informant Mrs Emma C. Durkin
(Address) 920 West Pratt St.

15 Filed _____, 19__ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Run down as he walked into side of moving truck
(a)
(duration) Instantaneous yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Broadway Pennsylvania Ave
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) H. J. Braun, M. D.
10/3, 1930 (Address) 1739 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	10/6 1930
20 UNDERTAKER John J. Cowan & Son	ADDRESS 901 Hollins

Important. See instructions on back of certificate.

...ec.—1-30—M. & T.—250 Bks.

E 61064

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61064

62

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 540 Oxford ST., 17-24 WARD)

2-FULL NAME Gertrude Harris

(a) RESIDENCE NO. 540 Oxford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12 1926

7 AGE Years 4 | Months 6 | Days 20 | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Fred. H. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Holmes (Address) 540 Oxford St

15 Filed ...19... Registrar

1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-2-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1930, to Oct. 2, 1930, that I last saw her alive on Oct. 2, 1930, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Aurora about 4 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Statutes Lymphaticus several months (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas H. Thompson M. D.

(Address) 912 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-4 1930

20 UNDERTAKER Hunt Parlors

ADDRESS 916 Pa Ave

pec.—1-30—M. & T.—250 Bks.

Bernard Smith

E 61065

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61065

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 N. Stricker ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Smith

(a) RESIDENCE NO. 904 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
M	C	S.

3a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 26-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Norman Smith

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Bernice Jennings

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Bernice Jennings
(Address) 904 N. Stricker

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3-30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1930, to Oct. 4, 1930, that I last saw h.. alive on Oct. 3, 1930, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mal nutrition

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.

(Address) 1512 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Oct 5 1930

20 UNDERTAKER Wm. H. Grace & Son

ADDRESS 46 Mosher

HAROLD JONES, M. D.
1930

pec.—1-30—M. & T.—250 Bks.

E 61066 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61066

CERTIFICATE OF DEATH.

1-PLACE OF DEATH The Church Home & Infirmary REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) N. Broadway ST. 6-4 (WARD)

2-FULL NAME Raymond Bullock

(a) RESIDENCE NO. 5 1/2 Washington ST., Oxander, N. Y.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Pickard Bullock

6 DATE OF BIRTH (month, day, and year) Aug. 9, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen. Manager & V.P.

(b) General nature of industry, business, or establishment in which employed (or employer) Metal Furniture Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Mass.
(State or country)

PARENTS

10 NAME OF FATHER Gilbert F. Bullock

11 BIRTHPLACE OF FATHER (city or town) Mass.
(State or country)

12 MAIDEN NAME OF MOTHER Nellie Mann

13 BIRTHPLACE OF MOTHER (city or town) R. I.
(State or country)

14 Informant Mary P. Bullock
(Address) Oxander, N.Y.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to October 3, 1930, that I last saw him alive on October 3, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Ruptured Appendicitis with General Peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Sept 30, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. Frank Hewitt, M. D.

Oct 3, 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamestown, N. Y.

DATE OF BURIAL Oct. 4, 1930

20 UNDERTAKER John A. Mitchell & Sons

ADDRESS 1900 Eutaw Place

pec.—1-30—M. & T.—250 Bks

E 61067 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61067

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH Walker Ave & Sherwood Rd

CITY OF BALTIMORE: (No. Sherwood Rd ST. 27-48 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Jackson

(a) RESIDENCE NO. Sherwood Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colrd

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Mary P.

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years 70; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md

PARENTS

10 NAME OF FATHER: Samuel Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Jackson

(Address): Same

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to Oct 3, 1930, that I last saw him alive on Oct 2, 1930, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows: Ch Ld Nephritis, Ch Myocarditis,

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. W. Bryant, M. D.

Oct 3, 1930 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooks Maryland

DATE OF BURIAL: Oct 6 1930

20 UNDERTAKER: Joseph A Lively

ADDRESS: 4099 Mountcastle

1-30—M & T.—100 B—50L

E 61068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 61068

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N. Vincent ST., 19-27 WARD)

2-FULL NAME Martha Burgess

(a) RESIDENCE NO. 223 N. Vincent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Burgess

6 DATE OF BIRTH (month, day, and year) Mar 28, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	32	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H. W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Albert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Taylor
(Address) 223 N Vincent

15 Filed ..... 192 ..... Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. H. Brownley, M. D. Coroner

10/2, 1930 (Address) 3601 Third Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion

DATE OF BURIAL Oct 4. 1930

20 UNDERTAKER Joseph A Lively

ADDRESS 1029 N Mount Street.

spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61069 — 129 E 61069

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 Penna Ave St. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jefferson Earley

(a) RESIDENCE NO. 1821 Penna Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Mar. 4, 1856

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Retail Sea-Food

(c) Name of employer Mrs. Clarence B Lennon

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Leonard Earley

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Y

12 MAIDEN NAME OF MOTHER Ruth Lyck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Y

14 Informant Mrs Clarence B Lennon (Address) 1821 Penna Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1928 to Oct. 4, 1930

that I last saw him alive on Oct 4, 1930

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows: Coronary Thrombosis

Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jonas Ehrenfeld, M. D.

Oct 4 1930 (Address) 709 W. Mt Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greene Mount

20 UNDERTAKER Harry W. Ehlen

DATE OF BURIAL Oct 6 1930

ADDRESS 1919 W. Mt

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

070 X 135 E 61070

CERTIFICATE OF DEATH

1—PLACE OF DEATH Maryland Gen. Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 11-24 WARD)

2—FULL NAME Mary Merryman

(a) RESIDENCE NO. York Rd. Lutherville, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 14-1846

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	8	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland-

10 NAME OF FATHER Geary L. Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland-

12 MAIDEN NAME OF MOTHER Emily Baud-

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland-

14 Informant Appel relative

(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 13-, 1930 to Oct 5, 1930, that I last saw h[illegible] alive on 10-5, 1930 and that death occurred, on the date stated above, at 5 55 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 10-1-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert J. Crane, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct. 7 1930

20 UNDERTAKER Wm. C. Butler & Son

ADDRESS Baltimore.

5-1930 C. HERMON JONES, M.

Spec.—1-30—M. & T.—250 Bks.

E 61071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61071

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2051 East Monument St. WARD 19)

2-FULL NAME Walter Morgan

(a) RESIDENCE NO. 2051 East Monument St. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

7 DATE OF BIRTH (month, day, and year) July 26 1875

8 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	2	7	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mason Stone
(b) General nature of industry, business, or establishment in which employed (or employer) 175
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Chas H. Morgan
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Amanda Hatten
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Laura Murray
(Address) 4617 Asbury Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Oct 3, 1930, that I last saw h[illegible] alive on Oct 3, 1930, and that death occurred, on the date stated above, at 7:10 P m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sign

(Signed) Joseph Pokorny M. D.

, 19 (Address) 2300 E Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 6 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 Sth Ave

C. HA[illegible]ONES, M.

Rec. 2-29-28—L. P. S.—500 Bks.

E 61072. HEALTH DEPARTMENT—CITY OF BALTIMORE E 61072

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 N Patterson Pk ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F Weitzel

(a) RESIDENCE NO. 803 N. Patterson Park ave ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 4th 1866

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer 034

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Martin Weitzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Horst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mollie H Weitzel

(Address) 803 N Patterson Park ave

15 Filed ..... 19..... JOSEPH JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4/ 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 , 1930 , to Oct 4 , 1930 , that I last saw h— alive on Oct 4 , 1930 and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Lobar

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anna Brennan, M. D.

Oct 7, 1930 (Address) 718 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Oct 7th 1930

20 UNDERTAKER George J Kelly & Sons

ADDRESS 1136 E Monument St

sec.—1-30—M. & T.—250 Bks

E 61073

E 61073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. 33 r Calvert Sts. 17-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Kerrigan

(a) RESIDENCE NO. 116 W. 24th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typist

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

009

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Kerrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Carty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Margaret Kerrigan (Address) 1716 E. Biddle St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1930 to Oct. 4, 1930, that I last saw her alive on Oct. 4, 1930, and that death occurred, on the date stated above, at 9:35 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) Unknown ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Sugar

(Signed) Francis W. Gluck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cathedral

DATE OF BURIAL 10/7 1930

20 UNDERTAKER W. M. Cook

ADDRESS 1217 St. Paul St

pec.—1-30—M. & T.—250 Bks.

E 61074

E 61074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 156

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1 St. 4-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Pinkney

(a) RESIDENCE NO. Elkridge ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): infant

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1929

7 AGE — Years: — Months: 11 — Days: 7 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Ernest Franklin Pinkney

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Jeanette Hawkins.

13 BIRTHPLACE OF MOTHER (city or town) Howard Cty. (State or country)

14 Informant (Address) Jeanette Pinkney Elkridge Md.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from September 21, 1930 to October 3, 1930, that I last saw him alive on Oct 3, 1930, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Sepsis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Epiphysitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Arnold M. Stark M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkridge Md.

DATE OF BURIAL: 10/5/1930

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1631 Druid Hill

pec.—1-30—M. & T.—250 Bks

E 61075 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61075

CERTIFICATE OF DEATH.

REGISTERED NO. 25-13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2604 Rittenhouse Ave (St.) (WARD)

2-FULL NAME John J. Van Herpt

(a) RESIDENCE NO. 2604 Rittenhouse Ave St. WARD 25

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? 23 yrs. 7 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 1872

7 AGE — Years: 58 — Months: 8 — Days: 25 — If LESS than 1 day, ...hrs. or ....min.

~~Jan 7, 1872~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Paint Co. 062

(c) Name of employer: Hirschberg Paint Co.

9 BIRTHPLACE (city or town) (State or country): Holland Europe

PARENTS

10 NAME OF FATHER: Adrianus Van Herpt

11 BIRTHPLACE OF FATHER (city or town) — (State or country): Holland

12 MAIDEN NAME OF MOTHER: Johanna A. Der Kinderen

13 BIRTHPLACE OF MOTHER (city or town) — (State or country): Holland

14 Informant: Mrs. Charles P. Van Herpt

(Address) 2604 Rittenhouse Ave. Balto. Md.

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1930, to Oct 2, 1930, that I last saw h... alive on Oct 2, 1930, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Oesophagus)

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Sept 1930

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Exam —

(Signed) Louis Krauss, M. D.

(Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md

DATE OF BURIAL: Oct 6 1930

20 UNDERTAKER: Jas. S. Taylor Sons

ADDRESS: Annapolis Md

pec.—1-30—M. & T.—250 Bks.

E 61076

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61076

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH Baltimore City Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 9-16 ST., ... WARD .....)

2-FULL NAME Ernst Heim

(a) RESIDENCE NO. 1837 Aiken ST., ... WARD ..... (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced (HUSBAND) of Eve Heim. (or) WIFE of .....

7 DATE OF BIRTH (month, day, and year) 9-17-52

8 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	78		20	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Given

(b) General nature of industry, business, or establishment in which employed (or employer) — ? 40

(c) Name of employer — ?

10 BIRTHPLACE (city or town) (State or country) York Pa.

PARENTS

10 NAME OF FATHER John Heim ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Bakeus

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Pa.

14 Informant Emanuel Heim (Address) 1837 Aiken St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-30

17 I HEREBY CERTIFY, That I attended deceased from 9-2-, 1930, to 10-4-, 1930, that I last saw h— alive on 10-4-, 1930, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid Colon

Lymph Gland Metastasis

Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... dys

CONTRIBUTORY (Secondary) Uncertain (duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Findings

(Signed) Fred M. Overstreet M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cem. York Pa

DATE OF BURIAL 10/5/30

20 UNDERTAKER George J. Puth Inc Funeral

ADDRESS 1730 Harford

pec.—1-30—M. & T.—250 Bks.

E 61077

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 61077

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hosp. REGISTERED NO. 44-37

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Downing

(a) RESIDENCE NO. 3322 Hudson ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced
HUSBAND of
or) WIFE of Isabella Downing.

6 DATE OF BIRTH (month, day, and year) May 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? 0 10

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Kentucky

PARENTS

10 NAME OF FATHER George Downing

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mary Kramling

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

14 Informant Records
(Address) Baltimore City Hospitals

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-2-30

17 I HEREBY CERTIFY, That I attended deceased from 6-15-, 1930, to 10-2-, 1930, that I last saw h[illegible] alive on 10-2-, 1930, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach with metastasis to liver

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 6-15-30

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings

(Signed) Fred M. Dunkenfield, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL Oct. 6th 1930

20 UNDERTAKER Lilly & Gilbert Co.

ADDRESS 403 E. Wolfe St

pec.—1-30—M. & T.—250 Bks

E 61078 HEALTH DEPARTMENT—CITY OF BALTIMORE 44E 61078

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 N. Milton Ave ST.; 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdelena Klein

(a) RESIDENCE NO. 1515 N. Milton Ave ST.; 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Klein

7 DATE OF BIRTH (month, day, and year) June 27 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John G. Klein

(Address) Chestertown, Md.

15 Filed ....., 19 ..... RLK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from March 25 - 1930, to Oct. 2 - 1930,

that I last saw h.. alive on " " 1930,

and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Gall Bladder

(duration) - yrs. 10 mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 8-1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Edwin D. Fenby, M. D.

10/3/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Oct. 6th 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St.

Dec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61079 — 162 — E 61079

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp ST., 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Zafrin

(a) RESIDENCE NO. 1912 E. Balto St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 10/4/30

AGE	Years	Months	Days	If LESS than 1 day 12 hrs or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) West Balto Gen. Hosp.

10 NAME OF FATHER Morris Zafrein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sadie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris Zafrein

(Address) 1912 E Balto St.

15 Filed ——, 19 —— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4/30

17 I HEREBY CERTIFY. That I attended deceased from 10/4, 1930, to 10/4, 1930

that I last saw him alive on 10/4, 1930

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis of Both Lungs
(Lived 12 hrs)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry Cohen, M. D.

Oct 5, 1930 (Address) West. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Cemetery

DATE OF BURIAL Oct 5 1930

20 UNDERTAKER S Lennon Bro

ADDRESS 1127 E Balto St

...c.—2-29-28—I. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61030

CERTIFICATE OF DEATH

122-002 E 61080

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2720 Manchester ST. 46 68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Byrne

(a) RESIDENCE NO. 2720 Manchester ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Hughes Byrne

DATE OF BIRTH (month, day, and year): Aug 16-1876

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	1	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Matron

(b) General nature of industry, business, or establishment in which employed (or employer): Matron

(c) Name of employer: Police Dept.

BIRTHPLACE (city or town) (State or country): Ireland

10 NAME OF FATHER: Hugh Clinton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Hanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Katherine Purcell

(Address) 2720 Manchester ST

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Oct 2nd, 1930, that I last saw h alive on Oct 2nd, 1930 and that death occurred, on the date stated above, at 7:10 a m.

The CAUSE OF DEATH* was as follows:

Cerebrosis of Cancer

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Ascites

(duration) ..... yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Mitchell M. D.

10/3, 1930 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 10/6 1930

20 UNDERTAKER: H. C. Browning Son

ADDRESS 1136 Poplar Grove St

Spec.—2-29-28—L. F. S.—500 Bks.

E 61081

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 61081

CERTIFICATE OF DEATH

1—PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 40th St + Kenwick ST. 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Catherine V. Jacobs

(a) RESIDENCE NO. Home for Incurables ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E. Jacobs

DATE OF BIRTH (month, day, and year) Sept 2-1851

AGE	79 Years	1 Months	2 Days	If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Horace Tydings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Kate Stinchcomb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

1 Informant Horace T. Jacobs

(Address) 3013 Gwynns Falls Pky

5 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 4-1930

17 I HEREBY CERTIFY, That I attended deceased from May 15 . 1930 to Oct 4 . 1930

that I last saw her alive on Oct 3 . 1930

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) T. J. Leitch, M. D.

. 19 (Address) Euxton - Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon-Park

DATE OF BURIAL Oct 6 1930

20 UNDERTAKER J. O. Mitchell

ADDRESS 1900 Futaw Pl.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61032

CERTIFICATE OF DEATH

90

E 61032

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1712 N. Fayette ST. 19-27 WARD)

2—FULL NAME Mary Kate Mundie

(a) RESIDENCE NO. 1712 N. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year): Feby 24 1852

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Ky.

10 NAME OF FATHER: James Mundie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Adeline Pettross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs Effie Curtis

(Address) 1712 N. Fayette St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30 1930 to Oct 4 1930

that I last saw her alive on Oct 4 1930

and that death occurred, on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Myocarditis Arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry E. Ohle, M. D.

19 (Address) 1032 N. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Oct 7 1930

DATE OF BURIAL

20 UNDERTAKER: John A. Mitchell Sons

ADDRESS: Essex Md

OCT 5 1930

Dec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61033 — 57 E 61033

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1650 E. 25th St. (Ward) 9-45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Johnson

(a) RESIDENCE NO. 1650 E 25th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert L. Johnson

6 DATE OF BIRTH (month, day, and year) May 29/1877

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Sterling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary — —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Albert L. Johnson (Address) 1650 E 25th St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1930, to October 3, 1930, that I last saw her alive on October 2, 1930 and that death occurred, on the date stated above, at 9 30 A.M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis. (Hemorrhage at the end)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical diagnosis

(Signed) J. W. Keown, M. D.

10/3/1930 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartzbem

DATE OF BURIAL Oct 6/30

20 UNDERTAKER Philip Henrig

ADDRESS 2016 Orleans St

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

61034 136E 61034

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Hathaway Edmonds

(a) RESIDENCE NO. 4711 Roland Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Eddie L. Edmonds

7 DATE OF BIRTH (month, day, and year) Oct. 11, 1857

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	23	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Editor & Publisher

(b) General nature of industry, business, or establishment in which employed (or employer) Mgr's Record

(c) Name of employer Jeff Norfolk Va

10 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Richard Henry Edmonds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Eliza Talley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Richard H. Edmonds

(Address) Wyndhurst Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1930, to Oct. 4, 1930,

that I last saw him alive on Oct. 4, 1930,

and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of the Prostate

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of the Heart (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Yes Date of Oct 4, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation. Clinical observation

(Signed) L. L. Lynn M. D.

10/6, 1930 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Oct 6 1930

20 UNDERTAKER Wm Fleckner Sons

ADDRESS North & Pa

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61035 | 131 E 61085

REGISTERED NO. 10-50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Dawson

(a) RESIDENCE NO. Calvert + Gilmor apts 31st Sts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) May 12 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
One (1)	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George H. Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Maryland

12 MAIDEN NAME OF MOTHER Anna Armiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Geo. H. Dawson (Address) Calvert & 31st St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1930, to Oct 4, 1930, that I last saw her alive on Oct 4, 1930, and that death occurred, on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH* was as follows:

Unknown

(duration) 0 yrs. 8 (?) mos ds.

CONTRIBUTORY (Secondary) (1) Pyelitis (2) Bronchopneumonia

(duration) yrs. mos. (2) 12 (1) ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical history

(Signed) Jesse S. Fuller, M. D.

10/4, 1930 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL Oct 6 1930

20 UNDERTAKER Wm. J. Kieffer Sons

ADDRESS North Ave

0—M. & T.—100 B—50L

E G1036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

181-004

E G1036

REGISTERED NO. 45-61

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Garage Rear Elsinore & Dorrell Aves ST. WARD

2-FULL NAME Howard B. Seim.

(a) RESIDENCE NO. Elsinore & Dorrell Aves ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Alice E. Seim

DATE OF BIRTH (month, day, and year): Aug 29-1883

AGE: Years 47 Months 1 Days 4 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Paint & Glass Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Henry H. Seim

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Anna Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Alice E. Seim
(Address): 2809 Elsinore Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct 1st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Carbon Monoxide Gas Poisoning Sudden

(duration) yrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Garage rear of home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Lueth, M. D.
Coroner

192 (Address) Bowie

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Oct 6 1930

20 UNDERTAKER: Wm. Pickrell Sons

ADDRESS: North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E·61087

90 B 61087

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 6613 Reisterstown Rd. St. 28-63 Ward)

2-FULL NAME Michael J. Glenn

(a) RESIDENCE NO. 6613 Reisterstown Rd., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7½ yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Madelena Kreeger

6 DATE OF BIRTH (month, day, and year) Jan 4 1884

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
46	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Office
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Dennis Glenn

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary McInes

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Michael Glenn
(Address) 6613 Reisterstown Rd

15 Filed ..... 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Tubercular Pneumonia Both Lungs

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Rossmeier, M. D.

Oct. 6, 1930 (Address) 9622 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Oct 6 1930
20 UNDERTAKER	ADDRESS
Martin Fahy & Sons	1827 N Howard

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 61088

E 61088

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (ST. 11-74 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME James Height

(a) RESIDENCE NO. 834 S. Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie

7 DATE OF BIRTH (month, day, and year) Feb. ?, 1875

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	8		

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gen

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Isabelle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ....., 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-30

17 I HEREBY CERTIFY, That I attended deceased from 9-17-30, 19.., to 10-4-30, 19.., that I last saw him alive on 10-4-30, 19.., and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic & Acute
Hypertension
Arteriosclerosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jas G Emerson Jr, M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll's Cemetery

DATE OF BURIAL Oct 7, 1930

20 UNDERTAKER Calvert Co. Md. John H. Toadvine

ADDRESS 1027 Hand St.

FILED "1938" HAMPSON JONES M.D.

ec.—2-29-28—I. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 V

E 61089

E 61089

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3713 Clifton Road ST. 13-57 WARD)

2—FULL NAME Edward C. LeBon

(a) RESIDENCE NO. 3713 Clifton Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 7-1872

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	7	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Linen Woman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto City

10 NAME OF FATHER Charles B. LeBon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine Kailer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

14 Informant Mrs Long

(Address) 3713 Clifton Road

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929, to Oct 3, 1930, that I last saw h alive on Oct 3, 1930 and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) Edward Heidenheimer M. D.

Oct 5, 1930 (Address) 858 N 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Oct 6 1930

20 UNDERTAKER ADDRESS

A. S. Marshall 2539 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61090

CERTIFICATE OF DEATH

113 ✓
E 61090

1—PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1024 Olive ST. 9-18 WARD)

2—FULL NAME Alma augusta Fitzhugh

(a) RESIDENCE NO. 1024 Olive St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ..... ds. How long in U. S., if foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX female | 4 COLOR OR RACE Black | 5 Single, Married, Widowed, or Divorced (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of .....

DATE OF BIRTH (month, day, and year) Aug 7 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Charles Fitzhugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Dunby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Charles Fitzhugh.
(Address) 1024 Olive St

15 Filed ..... 19 ..... C. HUMPHREYS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10.4.30

17 I HEREBY CERTIFY, That I attended deceased from 9.29.30, 19..., to 10.4.30. 19..., that I last saw h.. alive on 10.3.30, 19..., and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris M. D.

10.4.19 30 (Address) 107 East west St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a. a Co. | DATE OF BURIAL 10-6th 1930

20 UNDERTAKER E + B Harle 115 E | ADDRESS West St

pec.—1-30—M. & T.—250 Bks.

61091

HEALTH DEPARTMENT—CITY OF BALTIMORE

61091 E 61091

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2720 Harlem Ave St. 16 68 WARD)

2-FULL NAME Laura Weissenborn.

(a) RESIDENCE NO. 2720 Harlem Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paul. Weissenborn

6b DATE OF BIRTH (month, day, and year): FEB 2 1860

7 AGE: Years 70 | Months 8 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm. Sprengel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lena Strohbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Ernest. Weissenborn

(Address) 219 S Eaton St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 1930.

17 I HEREBY CERTIFY, That I attended deceased from September 1 1930 to Oct 4, 1930, that I last saw h[illegible] alive on Oct 3, 1930, and that death occurred, on the date stated above, at 1.30 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Generalized arteriosclerosis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Michel M. D.

Oct 4. 1930 (Address) 2901 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 10-6 1930

20 UNDERTAKER: Mrs Chas A G Rohde

ADDRESS: 2227 Edmondson Ave

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61092

CERTIFICATE OF DEATH

89 E 61092

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 274 N. Calvert ST. 17-50 WARD)

2—FULL NAME Nelson Howard Strickhoff

(a) RESIDENCE NO. 274 N. Calvert ST., WARD
(Usual place of abode)

(If non-resident give city or town and State)

ength of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary F. Strickhoff

DATE OF BIRTH (month, day, and year) Jan 22 1808

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Woodlawn Cemetery Co

BIRTHPLACE (city or town) (State or country) Baltimore Co., Md

10 NAME OF FATHER Frank Strickhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary F. Strickhoff

(Address) 274 N. Calvert St

15 Filed OCT 6 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29 1930 to Oct. 3, 1930, that I last saw him alive on Oct. 2, 1930 and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Ott Bayley, M. D.

Oct 3 1930 (Address) 2205 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cemetery Harford Co (London Park for Cremation for Burial)

DATE OF BURIAL Oct 6 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61093

E 61093

CERTIFICATE OF DEATH.

129 E.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Madison Ave St. 14-20 Ward)

2-FULL NAME Mary T. Bush

(a) RESIDENCE NO. 1508 Madison Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): M.

6a If married, widowed, or divorced (or) WIFE of: William Bush

6b DATE OF BIRTH (month, day, and year): 1894

7 AGE — Years: 36 — Months: — Days: — If LESS than 1 day, ...hrs. or ....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Sam T. Hyson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Rebecca Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Louisa Curtis 1508 Madison Ave

15 Filed ..... 19..... C. BAYARD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from ~~Oct~~ Sept 20, 1930, to Oct 3, 1930, and last saw h[illegible] alive on Oct 3, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Uremia Extreme Hypertension and. (duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? uncertain

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. Young, M. D.

Oct 4 1930 (Address) 1429 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M. Carlin

DATE OF BURIAL: Oct. 6 1930

20 UNDERTAKER: Sam'l W. Close & Son

ADDRESS: 1400 Mosher

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61094 × 129 E 61094

CERTIFICATE OF DEATH

REGISTERED NO. 46-22

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 N. Mount ST., 16 WARD)

2-FULL NAME Washington Luther Woodyard

(a) RESIDENCE NO 1123 N. Mount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Jane

6 DATE OF BIRTH (month, day, and year) Nov 5 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	6	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Judson Woodyard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eliza Jane Woodyard
(Address) 1123 N. Mount

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebro Cerebral Hemorrhage

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. K. Hedrick, M. D.
Coroner

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md

DATE OF BURIAL Oct 8 1930

20 UNDERTAKER H Bankard & Son

ADDRESS Westminster

pec.—1-30—M. & T.—250 Bks

E 61095

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61095

CERTIFICATE OF DEATH.

101-E 61095

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 W. Lexington ST. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence B. Watkins

(a) RESIDENCE NO. 506 W Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) June 29, 1900

8 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
30	3	3	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work @ home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Baltimore Md

11 NAME OF FATHER Samuel Watkins

12 BIRTHPLACE OF FATHER (city or town) (State or country) Md 60 Maryland

13 MAIDEN NAME OF MOTHER Risa Jackson

14 BIRTHPLACE OF MOTHER (city or town) (State or country) East side Virginia

PARENTS

14 Informant Sarah Butler

(Address) 506 W Cross

15 Filed ——— 19 ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2/30

17 I HEREBY CERTIFY, That I attended deceased from 9/30, 1930 to 10/2, 1930.

that I last saw h alive on 10/2, 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dan Drancken, M. D.

10/2/1930 (Address) 1422 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Oct 6, 1930

ADDRESS 322 W Saratoga St.

20 UNDERTAKER Mrs Katie R. Williams

10-1930 Harry Lee Jones M. D.

pec.—1-30—M. & T.—250 Bks

E 61096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 61096

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1406 Carroll ST. 21-28 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William N Bryan

(a) RESIDENCE NO. 1406 Carroll ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. + mos. + ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Bryan

7 DATE OF BIRTH (month, day, and year) 1870

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	+	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jury wagon

(b) General nature of industry, business, or establishment in which employed (or employer) & Hauling

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) St Marys Co Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Grace Bryan

(Address) 1406 Carroll

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3/30

17 I HEREBY CERTIFY, That I attended deceased from 9/28, 1930, to 10/3, 1930, that I last saw him alive on 10/3, 1930, and that death occurred, on the date stated above, at 11 40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy —

(duration) — yrs. — mos. 6 da.

CONTRIBUTORY (Secondary) Hypertension Chr Nephritis.

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urine +++

(Signed) Dan Grandin, M. D.

10/3 1930 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Oct 6, 1930

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 322 W Schroeder St

HAROLD C. HANSON JONES, M. D.

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E. 61097 — 24-001 E. 61097

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 70-20 WARD)

2-FULL NAME Elizabeth Benns

(a) RESIDENCE NO 103 N Caton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fmale	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas Benns

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nettie Waters

(Address) 2603 Bruce Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) Sudden yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas O Brooke M. D. Coroner

Oct 3, 1930 (Address) Broadway 22.4

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Churchville Md.

DATE OF BURIAL Oct. 6th 1930

20 UNDERTAKER Thomas C Kelson

ADDRESS 1303 Forrest Ave

Sec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61098

REGISTERED NO. E 61098

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 S. Ellwood ave. ST., 1-2 WARD)

2-FULL NAME Mary A. Broom

(a) RESIDENCE NO. 309 S. Ellwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Louis E. Broom

7 DATE OF BIRTH (month, day, and year) Aug. 5-1855

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward Harp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Louis E. Broom

(Address) 309 S. Ellwood ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3-1930.

17 I HEREBY CERTIFY, That I attended deceased from May 10-, 1928, to Oct 3, 1930, that I last saw h[illegible] alive on Sept 20, 1930, and that death occurred, on the date stated above, at 10.15 p m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatism

(duration) 5 yrs. mos da.

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of [illegible]

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Leo. H. Klein, M. D.

10-4, 1930 (Address) 1937 Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Oct 6 1930.

20 UNDERTAKER George W Zirkler

ADDRESS 1737 E. Eager st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 61099

1099

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) 26-1 (ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elizabeth Long.

(a) RESIDENCE NO. 1409 S. Clinton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER John Long.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Henry Long (Address) 1409 S. Clinton St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4 1930.

17 I HEREBY CERTIFY, That I attended deceased from 9/25 1929 to 10/4 1930, that I last saw her alive on 10/4 1930, and that death occurred, on the date stated above, at 10 18 P. m.

The CAUSE OF DEATH* was as follows:

Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma uteri (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert Beuer, M. D.

19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery

DATE OF BURIAL: Oct 8 1930

20 UNDERTAKER: George W. Zirkler

ADDRESS: 1737 E Lafayette

-30—M. & T.—100 B—50L

Anthony Liberto

E 61100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 16-67 WARD)

REGISTERED NO. 161-08 E 61100

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Liberto

(a) RESIDENCE NO 1400 Poplar Grove St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 25/30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Vincent Liberto

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Olivia R. Geppi

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Vincent Liberto
(Address) 1400 Poplar Grove St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature- 6-7 mons gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Carter, M. D.
Coroner

, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Oct 7 1930

20 UNDERTAKER W. W. Routson

ADDRESS 2228 N North

Dec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61101 | 13 | E 61101

REGISTERED NO.

61101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 27-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl C Walters

(a) RESIDENCE No. 5302 Tramor Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced (HUSBAND of or) WIFE of Margaret M Walter

6b DATE OF BIRTH (month, day, and year) Oct 11 89

6c AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Construction Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 0.30

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John P Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ottie Hamlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-30

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to Oct. 4, 1930, that I last saw him alive on Oct 4, 1930, and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Pernephritis Chronic

(duration) yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) J Leyko, M. D.

10/4, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL Oct 7 1930

ADDRESS 225 N Mtb

20 UNDERTAKER W. M. Rountree

pec.—1-30—M. & T.—250 Bks

E 61102

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61102

CERTIFICATE OF DEATH.

100-801

27-55

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd & Calvert ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olga Falk

(a) RESIDENCE NO. 5229 Park Heights Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Falk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER W. Buckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address) 33rd - Calvert Street -

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1930, to Oct. 5, 1930, that I last saw her alive on Oct. 5th, 1930 and that death occurred, on the date stated above, at 1:53 p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) about mos 21 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood chemistry

(Signed) Samuel McLanahan, M. D.

Oct 5, 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 10/8/1930

20 UNDERTAKER Wm Cook 1217 St Paul St

ADDRESS

1-30—M. & T.—100 B—50L

Roeper

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61103

CERTIFICATE OF DEATH

129 ✓ E 61103

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 S. Parrish ST. 19-28 WARD)

2-FULL NAME Wm Roeper

(a) RESIDENCE NO 419 S Parrish ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adel Roeper

6 DATE OF BIRTH (month, day, and year) Apr 28, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Chocolate Products Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adele Roeper

(Address) 419 S Parrish

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward Brown M. D.
Coroner

Oct 4 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 10/5/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

ec.—2-29-28—L. F. S.—500 Bks.

61704 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61704

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3316 Inchentonly St., [illegible] WARD) Jan 2-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Hirshberg

(a) RESIDENCE NO. 3316 Inchentonly WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 24 1855

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER William Hirshberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant [illegible] Mrs

(Address) 3316 Inchentonly Terrace

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5-1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to Oct 4, 1930,

that I last saw h[illegible] alive on Oct 4, 1930,

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Lloyd, M. D.

, 19 (Address) [illegible] Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cemetery

DATE OF BURIAL Oct 6/ 1930

20 UNDERTAKER J. Ahrens & Co

ADDRESS 2433 Pennsylvania Ave

pec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61105

CERTIFICATE OF DEATH.

129-E 61105

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 934 N. Wolfe ST. 9-13 WARD)

2-FULL NAME Mary E. Miller

(a) RESIDENCE NO. 934 N Wolfe ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Abraham Miller

6 DATE OF BIRTH (month, day, and year) Feb. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 010

(c) Name of employer

9 BIRTHPLACE (city or town) Drumond Woody
(State or country) Va

PARENTS

10 NAME OF FATHER Joseph Jefferson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary White

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Abraham Miller
(Address) 934 N. Wolfe St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1930, to Oct 3, 1930,

that I last saw her alive on Oct 3, 1930,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute exacerbation

Interstial Nephritis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY ...
(Secondary)

(duration) ... yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? Laboratory

(Signed) Calvin B. L. Compte, M. D.

, 19 (Address) 1113 N. Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem — DATE OF BURIAL 10-6 1930

20 UNDERTAKER J. Byron Wright 218 Mc Elderry St — ADDRESS

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61106

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 61106

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 406 N. Central Ave ST. 5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Matilda Armstrong

(a) RESIDENCE NO. 406 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) 1883

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Anne Arundel Co., Md

10 NAME OF FATHER Erasmus Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sophie Hall

(Address) 406 N. Monument St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-30

17 I HEREBY CERTIFY, That I attended deceased from 8-7- 1930, to 10-4 1930

that I last saw h alive on 10-4 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
acute Cardiac dilatation
Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 425 N. Carlin Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorothy Ann Arundel Co Md DATE OF BURIAL 10-7 1930

20 UNDERTAKER Byron & Wright ADDRESS 1218 McElderry St

ec.—1-30—M. & T.—250 Bks.

61107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 E 61107

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 S. Montford Ave ST. 1-13 WARD)

2-FULL NAME Adam Sobol

(a) RESIDENCE NO. 615 S. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 30 1925

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or ....min.
	5	9	5	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Anthony Sobol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Bertha Bielik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anthony Sobol (Address) 615 S. Montford Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1930, to Oct 5, 1930, that I last saw h— alive on Oct. 5, 1930, and that death occurred, on the date stated above, at 1 00 P. m.

The CAUSE OF DEATH* was as follows:

Infantile Cerebral Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Andrew Kurcrosk, M. D.

10/5, 1930 (Address) 2589 Eastern Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL Oct 7 1930

20 UNDERTAKER John M Weber

ADDRESS 1514 Chester

Spec.—12-9-25—A Co.—200 Bks.

E 61108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 VE 61108

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 825 Warner St. 27-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bandle

(a) RESIDENCE NO. 825 Warner St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Bandle

6 DATE OF BIRTH (month, day, and year) Apr. 7th 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home

9 BIRTHPLACE (city or town) Howard Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town) (?)

(State or country)

12 MAIDEN NAME OF MOTHER Laura Dorsey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant

(Address) 825 Warner St

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/1, 1930, to 10/4, 1930, that I last saw h[illegible] alive on 10/4, 1930, and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D H Carroll, M. D.

(Address) 830 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Oct 7 1930

20 UNDERTAKER A. L. Brown & Son ADDRESS 108 N. Monty

very important. See instructions on back

Spec.—1-30—M. & T.—250 Bks.

E 61109

61109 2-10-928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 22-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Schoats

(a) RESIDENCE NO. 724 Grundall Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 20 1930

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
/	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Grady Schoats

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Eliza Swart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

C. H. HANSON

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930, to Oct 3, 1930, that I last saw her alive on Oct 3, 1930, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Positive sputum

(Signed) R. O. H. Warner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion

DATE OF BURIAL Oct 6 1930

20 UNDERTAKER A. L. Brown & Son

ADDRESS 1018 N. Mar[illegible]

Spec.—12-9-25—A Co.—200 Blks.

E 61110

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61110

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. The Home for the Aged 700 N. Fulton Ave (Ward) 20-27

2-FULL NAME Miss Emily M. Hall.

(a) RESIDENCE NO. Home for the aged of the M.E. church Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ✓ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct. 6 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town)

(State or country) Ohio.

PARENTS

10 NAME OF FATHER Thomas H. Hall

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Sophia Shannon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ohio

14 Informant Etta Cuddy

(Address) 400 N. Fulton Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 1930, to Oct 4, 1930, that I last saw h[illegible] alive on Oct. 4, 1930, and that death occurred, on the date stated above, at 4.30p m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ✓ yrs. 3 mos. ✓ ds.

CONTRIBUTORY (Secondary) Chronic Arthritis

(duration) 7 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted ✓

If not at place of death!

Did an operation precede death! No Date of ✓

Was there an autopsy! No

What test confirmed diagnosis! Clinical Methods

(Signed) George C. Shannon, M. D.

10/4, 1930 Address 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Date of Burial Oct 6 1930

20 UNDERTAKER George Smith & Sons ADDRESS 1532 Hollins

C. HAMILTON JONES, M. D.

1930

Very important. Use typewriter if possible.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61111

CERTIFICATE OF DEATH.

129 E 61111

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Wallace

(a) RESIDENCE NO. 1210 Asquith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Wallace

6 DATE OF BIRTH (month, day, and year) 7-20-1860

7 AGE	Years	Months	Days	If LESS than 1 day ~~hrs~~ or ~~min~~
	70	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Highways Dept

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Mrs Minnie Wallace

(Address) 1210 Augusta St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5- 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-2 , 1930 , to 10-5 , 1930 ,

that I last saw him alive on 10-5 , 1930 ,

and that death occurred, on the date stated above, at 4 30 a m.

The CAUSE OF DEATH* was as follows:

Hypertension Cardio Vascular Renal disease with fever and Uremia Intoxication

(duration) one yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy by L.C.

(Signed) Hyman S. Anderson , M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL All Saints Cem. Pikesville

DATE OF BURIAL 10/7/30 19

20 UNDERTAKER George J Smith Inc

ADDRESS 1730 Harlem

Rec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61712

E 61712

CERTIFICATE OF DEATH.

24-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME Annie M. Clarke

(a) RESIDENCE NO. Preston & Valley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) .....

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	67			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER T. L. Clarke

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Chase

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley St

15 Filed ..... 19 ..... C. J. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6/30.

17 I HEREBY CERTIFY, That I attended deceased from 10/1, 1930, to 10/6, 1930, that I last saw h... alive on 10/5, 1930, and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr Bernard Wall, M. D.

10/6, 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 10-6 1930

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Fremont Ave

-30—M. & T.—100 B—50L

E 61113

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E 61113

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 Collins ST. 20-21 WARD)

2-FULL NAME August E Winters Sr

(a) RESIDENCE NO. 143 Collins ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Winters

6 DATE OF BIRTH (month, day, and year) Apr 5 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Francis J Winters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M. Winters

(Address) 143 Collins

15 Filed ....., 192 .. [illegible] Registrar

C-1030

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. O'Brooke Coroner M. D.

Oct 4, 1930 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U.S. National

DATE OF BURIAL 10/7 1930

20 UNDERTAKER Robert Brooke & Son

ADDRESS Calhoun & Hollins Sts.

ec.—2-29-28—L. F. S.—500 Bks.

E 61114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓ E 61114

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 2342 W. Fayette St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Emmet

(a) RESIDENCE NO. 2342 W. Fayette St.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. 3 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Emmet

DATE OF BIRTH (month, day, and year) June 11 1841

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89	3	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of indostry, business, or establishment in which employed (or employer) Black Smith

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Christian Emmet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Laura V. Hammer

(Address) 2342 W Fayette

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1930

17 I HEREBY CERTIFY, That I attended deceased from October 8, 1930, to October 5, 1930,

that I last saw him alive on October 5, 1930

and that death occurred, on the date stated above, at 8 20 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Stearns, M. D.

10/5, 1930 (Address) 1901 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 8 1930
20 UNDERTAKER	ADDRESS
Jos Joesdens Son	2173 Pa

dec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61115 — 29 E 61115

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. Enroute to Maryland Gen. Hospital ST.. 425 WARD)

2-FULL NAME Vincent Manzullo. Jr.

(a) RESIDENCE NO. 176 N. Pearl ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

DATE OF BIRTH (month, day, and year) 11/14/1923

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	16	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none. ad
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

8 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Vincent Manzullo
11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)
12 MAIDEN NAME OF MOTHER Rose Lamartina
13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Mrs Rose Manzullo
(Address) 176 N Pearl St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5-30.

17 I HEREBY CERTIFY, That I attended deceased from Sept 15- 1929, to Oct 4th 1930,
that I last saw him alive on Oct 4th 1930,
and that death occurred, on the date stated above, at 7 Yr P. m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease -
Mitral Stenosis
Nephritis
(duration) 1 yrs. mos 21 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Allowed
What test confirmed diagnosis?
(Signed) Wells Henning M. D.
10/6, 1930 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer
20 UNDERTAKER John Ulrich

DATE OF BURIAL Oct 8 1930
ADDRESS 2008 Orleans

Dec.—1-30—M. & T.—250 Bks.

239872
E 61116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 E 61116

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Kopp

(a) RESIDENCE NO. 429 N. Linwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Unknown

6 If married, widowed, or divorced HUSBAND of or) WIFE of Widower

7 DATE OF BIRTH (month, day, and year) Dec-14-1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) Merchant Retired

(c) Name of employer ditto

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-4-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Oct 4, 1930.

that I last saw h.im alive on Oct 4, 1930,

and that death occurred, on the date stated above, at 9 15 P m.

The CAUSE OF DEATH* was as follows:

Uremia following pyelonephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Benign prostatic hypertrophy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-25-30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Hugh J. Jewett, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood Cem

DATE OF BURIAL Oct 7 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

sec.—1-30—M. & T.—250 Bks.

241295 E 61117

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-002 E 61117

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-1 WARD)

2-FULL NAME John Tribull

(a) RESIDENCE No. 807 S. Kenwood ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

a If married, widowed, or divorced HUSBAND of or) WIFE of .....

DATE OF BIRTH (month, day, and year) Jan-1-1930

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Vita French

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-3, 1930, to Oct 4, 1930, that I last saw him alive on Oct-4, 1930, and that death occurred, on the date stated above, at 9 30A m.

The CAUSE OF DEATH* was as follows:

1 Dysentery, acute bacillary

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Robert O. Y. Warren, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Oct-7 19 30

20 UNDERTAKER Schmidt's

ADDRESS 2008 Eutaw

Cor.—10-10-29—A.G.—100-BK

E 61118 ✓E 61118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 231 E. North Ave. St., 9-14 (Ward)

2-FULL NAME Clara Wilson Shepherd.

(a) RESIDENCE NO. 231 E. North Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ——— ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White.	Widow.

5a If ~~single, married, widowed, divorced~~ (or) WIFE of Frank Lockwood Shepherd.

6 DATE OF BIRTH (month, day, and year) October 29, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER W. Wilson Byrn.

11 BIRTHPLACE OF FATHER (city or town) Maryland.
(State or country)

12 MAIDEN NAME OF MOTHER Clara White.

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania.
(State or country)

14 Informant F. Byrn Shepherd. (son)
(Address) 1424 Park Ave.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 5, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhard, M. D.

10/6, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md. DATE OF BURIAL 6 1930

20 UNDERTAKER H. M. Cook 1424 Park Ave ADDRESS

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61119 E 61119 31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST., 5-8 WARD)

2-FULL NAME Albert Rankin

(a) RESIDENCE NO. 628 N. Central ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced (HUSBAND of or) WIFE of Louisa Rankin

7 DATE OF BIRTH (month, day, and year) Jan. 2, 1888

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Rankin

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Hospital Records
(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1930, to Oct. 1, 1930, that I last saw him alive on Oct. 1, 1930, and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic cardio-vascular renal disease (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) David Seiver, M. D.

10-1, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL OCT 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

C. HAMPSON JONES, M. D.

PAT. WM. A. WOODALL

pec.—1-30—M. & T.—250 Bks.

Cobb

E 61120

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61120

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH Baltimore City Hospitals ST. 36-37 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Louis Cotto.

(a) RESIDENCE NO. Patt & Jefferson Parade ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Colord	Widowed

6a If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth Cotto.

6 DATE OF BIRTH (month, day, and year) Aug 14, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71		1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Gingo Cotto.

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Va.

12 MAIDEN NAME OF MOTHER Lavina Ramey

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Va.

14 Informant (Address) Records Baltimore City Hospitals

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-1-30

17 I HEREBY CERTIFY, That I attended deceased from 9-24, 1930, to 10-1, 1930, that I last saw him alive on 10-1, 1930, and that death occurred, on the date stated above, at 3-15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Prostate

(duration) unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Fred M. Dunkerly M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL OCT 1930

ADDRESS

20 UNDERTAKER Commissioner Health

HENRY C. HAMPSON JONES, M. D.

pec.—1-30—M. & T.—250 Bks

E 61121 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61121

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. [illegible] ST. 16-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Tuckey.

(a) RESIDENCE NO. None ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

7 DATE OF BIRTH (month, day, and year): 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Records

(Address) BALTIMORE CITY [illegible]

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1927, to Oct. 1, 1930, that I last saw h[illegible] alive on Oct. 1, 1930, and that death occurred, on the date stated above, at 10:15 A. m.

The CAUSE OF DEATH* was as follows:

Dementia, Senile

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis, unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

10-2, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: OCT 6 1930

20 UNDERTAKER

ADDRESS

C. HAMILTON JONES, M. D. Commissioner Health.

6 1930

1-30—M. & T.—100 B—50L.

E 61122

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61122

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital St. H 30 (WARD)

2-FULL NAME James Hodrell

(a) RESIDENCE NO Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant .....
(Address) .....

15 Filed ..... 192 ..... Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zellers, M. D. Coroner

9/30. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cremated and buried in Mt Olivet Cemetery

DATE OF BURIAL 10-10 1930

20 UNDERTAKER J. A. Funk

ADDRESS 784 Druid Hill Ave

C. HAMPSON JONES, M.D. JOHNS HOPKINS HOSPITAL Commissioner of Health

OCT 1 1930

Dec.—1-30—M. & T.—250 Bks

Irwin

E 61123

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61123

CERTIFICATE OF DEATH.

111-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Irwin

(a) RESIDENCE NO. Salvation Army, Balto. Md. St., WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed ..... 19.... C. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29/30

17 I HEREBY CERTIFY, That I attended deceased from 9/14/30, 19.... to 9/29/30, 19....

that I last saw him alive on 9/29/30, 19....

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Pyloric ulcer –

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diffuse Peritonitis –

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home –

Did an operation precede death? Yes – Date of 9/25/30 –

Was there an autopsy? No –

What test confirmed diagnosis?

(Signed) George H Yeager, M. D.

9/29, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19....

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health

OCT 6 1930

Dec. 2-20-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 61124

E 61124

CERTIFICATE OF DEATH

90

REGISTERED NO. 27-453

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. 6114 Birchwood Ave ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Hoffman

(a) RESIDENCE NO. 6114 Birchwood Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of George Hoffman

DATE OF BIRTH (month, day, and year) October, 18th 1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Mr Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) U S

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Alice Deinlein
(Address) 6114 Birchwood Ave.

15 Filed 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/3/1930 to 10/5/1930 that I last saw her alive on 10/5/1930 and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:
Acute dilitation of heart

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Lee Magness, M. D.

10/5/1930 (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Oct. 7th 1930

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 N Gay St

Dec.—1-30—M. & T.—250 Bks.

E 61125 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61125

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2705 Edmondson Ave. ST. 70-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Heller,

(a) RESIDENCE NO. 2705 Edmondson Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Katie Horisberg Heller,

7 DATE OF BIRTH (month, day, and year) August 10.1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Milwaukee Wisconsin,

PARENTS

10 NAME OF FATHER Charles Heller,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Katie H. Heller (Address) 2705 Edmondson Ave.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 19 29 to Oct 4 19 30, that I last saw h wife alive on Oct 4 19 30 and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) ✓ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Exam

(Signed) Thos Lear M. D.

10/6 19 30 (Address) 705 Med Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL OCT 7 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

HAMILTON JONES, M.

1-30—M. & T.—100 B—50L

E 61126

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61126

CERTIFICATE OF DEATH

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) Garage Rear 3434 Piedmont St. (Ward) 15th

2-FULL NAME Wm P. Smith

(a) RESIDENCE NO 3434 Piedmont St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Smith

6 DATE OF BIRTH (month, day, and year) Jan 21-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumbing Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Carrie Smith

(Address) 3434 Piedmont St

15 Filed ..... 192 ..... Registrar

C. HAMPSON JONES M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sarcoma

Carbon Monoxide Gas (duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Garage Rear 3434 Piedmont St

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) ..... M. D. Coroner

Oct. 10 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL Oct 8 1930.

20 UNDERTAKER Geo W. Little

ADDRESS 1700 Edmondson Ave

Spec.—1-10-21—M&T—1500 Blks.

E 61122

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

12-50 129 E 61127

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 316 E 22½ St (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H Sterling

(a) RESIDENCE No. 316 E 22½ St St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Sterling

6 DATE OF BIRTH (month, day, and year) Feb 12 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Lewis Henery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dor Chester Co Md

12 MAIDEN NAME OF MOTHER Hester Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dor Chester Co Md

14 Informant Cecil Sterling

(Address) 316 E 22½ St

15 Filed Oct 9 1930 C. HAMPSON JONES, M. D. Registrar R. C. H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1930, to Oct 4, 1930, that I last saw h alive on Oct 4, 1930 6:10 P m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Interstial Nephritis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Urinary

(Signed) C. C. Johnson M. D.

, 19 (Address) 2309 Fenwick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Oct 7 1930

20 UNDERTAKER Rayner & Sanders

ADDRESS 1413 E Preston St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61128

CERTIFICATE OF DEATH

90 E 61128

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1420 Cherry St. Curtis Bay St. 25-7 Ward)

2-FULL NAME Paul Dymicki.

(a) RESIDENCE NO. 1420 Cherry St. Curtis Bay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 22 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, HUSBAND of Balvina Dymicki.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Dymicki.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Balvina ----

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant (Address) Mrs. Wisniewski. (niece) 1420 Cherry St. Curtis Bay.

15 Filed ..... 19.. C. HARRISON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 4, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilotation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

10/6. 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Oct 7 1930

DATE OF BURIAL

20 UNDERTAKER: F W Ozarowski

ADDRESS 1930 Eastern Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61129 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61129

CERTIFICATE OF DEATH.

REGISTERED NO. 100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2843 Huntington Ave St., 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. Lambert

(a) RESIDENCE NO. 2843 Huntington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mollie Lambert

7 DATE OF BIRTH (month, day, and year) Nov 24 1872

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Richard M. Lambert

(Address) 2244 Pinkney St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 2d, 1930, to Oct 6, 1930,

that I last saw h alive on Oct 6, 1930,

and that death occurred, on the date stated above, at 5 20 p. m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B. Kadow M. D.

19 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Oct 8 1930

20 UNDERTAKER C. Harrison Jones, Inc.

ADDRESS 3615 Eastern Ave

6-1930

-30—M. & T.—100 B—50L

E 61130

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 61130

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 70-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Fisher

(a) RESIDENCE NO. 2620 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Jno. A. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Agnes L. Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wav

14 Informant Mr. J. A. Fisher

(Address) 2620 Frederick Ave

15 Filed ..... 192.... Registrar

1930 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident. Dress caught fire playing with matches at home

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brown M. D. Coroner

Oct 5, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 10/7 1930

20 UNDERTAKER: J. F. Gallagher & Sons

ADDRESS 918 Light

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61131 × 129 E 61131

REGISTERED NO.

1-PLACE OF DEATH U.S. Marine Hospital
CITY OF BALTIMORE: (NO. Baltimore, Md. ST. 12-51 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Burton L. Trott

(a) RESIDENCE NO. 42 Century St., West Medford, Mass. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Daisy G. ~~Trott~~ Trott

7 DATE OF BIRTH (month, day, and year) March 2 1887

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	7	29 4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Seaman 030
(c) Name of employer SS ARTIGAS

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER William Trott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastport Maine

12 MAIDEN NAME OF MOTHER Mina Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 3, 19 30 to October 6, 19 30, that I last saw h... im alive on October 6, 19 30, and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Cardiac hypertrophy
Hypertension, artery
Generalized arteriosclerosis unknown
Nephritis, chr (duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Cardiac decompensation with pul. edema (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & laboratory findings
(Signed) Gordon A. Abbott, M. D.
10/6 1930 (Address) US Marine Hospital, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stonington, Maine.
DATE OF BURIAL Oct. 7 1930
20 UNDERTAKER Henry Sander & Sons, Inc.
ADDRESS Baltimore St. & Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61132 | 188-203 | E 61132

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balto City Hos. St., 26-37 Ward)

2-FULL NAME Guy Irwin Reynolds Jr

(a) RESIDENCE NO. 2 Macon Essex St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov 9-1924

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	9		27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) and
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Guy I Reynolds

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Bertha E Lee

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Guy I. Reynolds, Sr.
(Address) 2nd & Macon Ave Essex

15 Filed ..... 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & Run over by moving auto
1a
I (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Struck & Killed
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Franklin & Macon Ave
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Obvious
(Signed) L Shapiro M. D.
10 6. 1930 (Address) 2934 N. Edgar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Oct 9 1930

20 UNDERTAKER George W. Zibler

ADDRESS 737 E. Eager st.

...ec.—1-30—M. & T.—250 Blks.

E 61133

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61133

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... St. 76-37 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Dowd

(a) RESIDENCE NO. 527 Dunkirk ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 6 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) 9-30-30

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edmond Dowd

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Rae ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Mother (Address) Baltimore City Hosp.

15 Filed ....., 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6-30

17 I HEREBY CERTIFY, That I attended deceased from 9-30 —, 1930, to 10-6-, 1930, that I last saw h[illegible] alive on 10-6-, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Extensive hemorrhage of brain

(duration) ... yrs. ... mos 6 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) Fred M. Duckwall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthews Cem.

20 UNDERTAKER John Ulmet

DATE OF BURIAL Oct 1, 1930.

ADDRESS 200 E Pleasant St

C. HAMILTON BOOTHE, M.D.

Registrar

OCT 1 1930

pec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61134 E 61134

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Lanham ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Wilson.

(a) RESIDENCE NO. 604 Lanham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE — Years: 65 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8a OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Chas Wilson (Address) 604 Lanham St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15th. 1930 Oct. 4th. 1930.

that I last saw her alive on Oct. 3rd, 1930

and that death occurred, on the date stated above, at 4.10 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Ins. and Ch. Int. Nephritis

About a year, from history ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted At place of D
If not at place of death?

Did an operation precede death No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis and Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Oct 7 — 1930

20 UNDERTAKER: Arnold Hensley

ADDRESS: 1538 N Eutaw

—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61135

CERTIFICATE OF DEATH.

129

REGISTERED NO. 1335

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto. City Hosp. ST. 14-27 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Scott

(a) RESIDENCE NO. 1721 - Cairo ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~ or Divorced, (write the word)
Male	Colored	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Bettie Scott

7 DATE OF BIRTH (month, day, and year) 1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
-	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer A. A Co md

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Robert Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Bradford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Bettie Scott (Address) 1721 Cairo St.

15 Filed 10-7-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to Oct. 5, 1930,

that I last saw h[illegible] alive on Oct. 5, 1930,

and that death occurred, on the date stated above, at 2 45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile heart disease arteriosclerosis - hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Oct 8, 1930

20 UNDERTAKER Thomas E Nelson

ADDRESS 1303 Pres[illegible]

ec. 2-29-28—L. F. S.—500 Bks.

E 61136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 61136

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 826 Brantley ST. 16th (WARD)

2—FULL NAME William Thomas

(a) RESIDENCE NO. 826 Brantley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About 52				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: C Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0+0

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Unknown

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Neighbor

(Address) 826 Brantley St.

15 Filed ..., 19... JUL JONES, M. ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1930, to Oct 6, 1930, that I last saw h/m alive on Oct 5, 1930, and that death occurred, on the date stated above, at 1 10A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation (Cardiac)
Hypertensive Cardiac
Vascular Renal Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine & Blood Pressure

(Signed) George MC Donald M. D.

, 19 (Address) 1900 W Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 10/7/1930

20 UNDERTAKER: Mrs. Geo. B. Holland

ADDRESS: 1631 Druid Hill

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

181-001 ✓

E 61137

E 61137

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 11-7 Ward)

2-FULL NAME William Girard.

(a) RESIDENCE NO. 22 E. Centre St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If ~~married, widowed, or~~ HUSBAND of ~~wife of~~ Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	65	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: News paper salesman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Catholic Center.
(Address) 415 Cathedral St.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 6, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating gas poisoning.
Accidental Death.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? 22 E. Centre St. October 3, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto M. Fernhardt, M. D.

10/7, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	10/7 1930
20 UNDERTAKER J. F. Thompson	ADDRESS 318 E. Eight

important. See instructions on back of certificate.

rec.—1-30—M. & T.—250 Bks.

E 61138 ✓ E 61138

E 61138
24077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 5-8 (WARD)

2-FULL NAME William Keister

(a) RESIDENCE NO. 1113 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Gibbons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

H. C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-4-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept-17, 1930 to Oct-4, 1930, that I last saw him alive on Oct-4, 1930, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia,
Cirrhosis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) H C Smith M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 10/7/1930

20 UNDERTAKER Harry A. Witzke, 4101 Edmondson Ave

ADDRESS

sec.—1-30—M. & T.—250 Bks

E 61139 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61139

CERTIFICATE OF DEATH.

REGISTERED NO. 161-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 28-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Hodges.

(a) RESIDENCE NO. 4561 Liberty Heights Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 6, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Dannycroft Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore.

12 MAIDEN NAME OF MOTHER Anna Lou Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winnipeg

14 Informant Hospital records.

(Address)

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Oct 6, 1930, that I last saw him alive on Oct 6, 1930, and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) G. Burns Mansfield, M. D.

Oct 6, 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL 10/7 1930

20 UNDERTAKER George A Talley Fulton & Fayette ADDRESS

10-7-1930 H. JONES, M. D. Registrar

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

202 ✓

E 61140

REGISTERED NO. E 61140

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Hospital St. 24-33 Ward)

2-FULL NAME Charles. G. Rabenau

(a) RESIDENCE NO. 1115 William St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 1 mos. 15 ds. How long in U. S., If of foreign birth? If Yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~per~~) of Mrs. Anna Rabenau

6 DATE OF BIRTH (month, day, and year) August-21-1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	30	1	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineeer for
(b) General nature of industry, business, or establishment in which employed (or employer) Arundel Wilcox & Engineeering Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Rabenau

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Katherine. M. Hergenrother

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Mr. William Rabenau
(Address) 560 N. Gay St.

15 Filed ..., 19.. ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1930 October-6-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed L. chest
puncture Lung Injury
Hemorrhage accident

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pot fellon Rim

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

(Address) 7002 Avenue St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer Cemetery — DATE OF BURIAL Oct. 10 1930

20 UNDERTAKER Henry Hoeck Sons, Inc. — ADDRESS 1301 E Eager St

Important. See instructions on back of this sheet.

...-1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61141

43

E 61141

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 E 20th St. 9-46 WARD)

2-FULL NAME Aloysius B. Zettmeist

(a) RESIDENCE NO. 1913 E. 20th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds. How long in U. S., if of foreign birth? 47 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Irene E Zettmeist

7 DATE OF BIRTH (month, day, and year) Apr. 20 1880

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sun Paper Route

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Aloysius B. Zettmeist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine B. Regner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Irene E Zettmeist

(Address) 1913 E 20th St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 6 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15 1930 to Oct 5th 1930

that I last saw h... alive on ....., 19....

and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Lingual Carcinoma

(duration) ....yrs. 4 mos ....ds.

CONTRIBUTORY (Secondary) Neurasthenia

(duration) ....yrs. ....mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. O. Owen M. D.

(Address) 4 Gay Dolphin Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Oct 8 1930

20 UNDERTAKER Henry Koch Sons, Inc.

ADDRESS 1301 E Eager St

...-1939 HAMPSON JONES, M. D.

-30—M. & T.—100 B—50L

E 61142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 61142

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 18-29 (WARD)

2-FULL NAME Eva Stanleis

(a) RESIDENCE No 833 Hollins ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Stanleis

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Walter Stanleis
(Address) 833 Hollins St.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Feller M. D.
Coroner

10/6, 1930 (Address) 239 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 10/8 1930

20 UNDERTAKER Chas. B. Kuchaus Sr — ADDRESS 631 S Paca St

20—M. & T.—100 B—60I.

E 61143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 61143

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 Roslyn Ave DIST. 15-61 WARD)

2-FULL NAME Harry E. Smith

(a) RESIDENCE NO 2206 Roslyn Ave DIST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 59 yrs. 10 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Smith

6 DATE OF BIRTH (month, day, and year) Nov 8-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Elon Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Jane Converse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Gertrude Smith

(Address) 2206 Roslyn

15 Filed ... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1930

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Autopsy thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) ... Coroner ... M. D.

(Address) Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Marysville Ohio

DATE OF BURIAL Oct 8 1930

20 UNDERTAKER Stewart & Mosner Co

ADDRESS Baltimore

Spec.—1-30—M. & T.—250 Bks.

E 61144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 61144

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 3040 St. Paul ST., 12 WARD
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Foxhall Nolley

(a) RESIDENCE NO. 3040 St. Paul ST., 12 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth 56 yrs. 3 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Lucy Riley Nolley

7 DATE OF BIRTH (month, day, and year) June 16 1874

8 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Advertising Mgr.
(b) General nature of industry, business, or establishment in which employed (or employer) for the Lord
(c) Name of employer Belvidere Hotel

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Marcellus Nolley
11 BIRTHPLACE OF FATHER (city or town) Parksburg
(State or country) Virginia
12 MAIDEN NAME OF MOTHER Edmonia Y. Sterman
13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Mrs Lucy Riley Nolley (wife)
(Address) 3040 St. Paul St. City

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1928, to October 6, 1930, that I last saw h— alive on October 6, 1930, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds. †

CONTRIBUTORY (Secondary) Chr. Bright's Disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Harry E. Wilson, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery — DATE OF BURIAL Oct 8, 1930.

20 UNDERTAKER Stewart & Company — ADDRESS Balto.

Spec.—1-10-21—M&T—1500 Bks.

E 61145 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61145

CERTIFICATE OF DEATH. 43

REGISTERED NO. 25-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. WARD)

2-FULL NAME Mr. William Silverman

(a) RESIDENCE NO. 805 W. Virginia Ave ST. Dunbar W Va WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Lena Silverman

6 DATE OF BIRTH (month, day, and year): Feb 7 1869

7 AGE: Years 61 Months 7 Days 29 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rochester Pa

PARENTS

10 NAME OF FATHER: Abraham Silverman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sarah Chisel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Lena Silverman 805 W. Virginia Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-6 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-26 1930 to 10-6 1930

that I last saw him alive on 10-6 1930

and that death occurred, on the date stated above, at 1 55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

Secondary metastasis

(duration) 1 mo yrs. mos ds.

CONTRIBUTORY (Secondary)

Coronary Occl (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs - Tolson Test

(Signed) Thomas Anderson, M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charleston W Va — DATE OF BURIAL: 9/7/30

20 UNDERTAKER: J. Ahnast & Co — ADDRESS: 2432 Eastern Blvd

THIS IS very important

Dec.—1-30—M. & T.—250 Blks.

Dr Rosenthal
2311 Eutaw Place ✓

E 61146 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61146

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 W. 33rd St. (Ward) 13-52

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen May Langford

(a) RESIDENCE NO. 520 W. 33rd St. ST., _____ WARD _____
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

7 DATE OF BIRTH (month, day, and year) Aug 16th 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1 10 mon	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Elroy C.
11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)
12 MAIDEN NAME OF MOTHER Agnes M. Polacek
13 BIRTHPLACE OF MOTHER (city or town) Bohemia
(State or country)

14 Informant Elroy C. Langford
(Address) 220 W. 33rd St

15 Filed ....., 19.... AHH. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Oct 6, 1930,
that I last saw h[illegible] alive on Oct 6, 1930,
and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:
Pneumonia (bronchio-) ventr
(duration) yrs. mos 1 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Gilbert W Rosenthal M. D.
Oct 6. 1930 (Address) 2311 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 10/8 1930

20 UNDERTAKER Tolson Cook — ADDRESS 1210 Park St

Spec.—1-30—M. & T.—250 Blks

E 61147 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-00 E 61147

CERTIFICATE OF DEATH.

REGISTERED NO. 27-43

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Mercy Hospital ST. WARD
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi L. Robinson

(a) RESIDENCE NO. 3123 Rosalie Ave ST., Hamilton WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mrs. Anna Robinson

7 DATE OF BIRTH (month, day, and year) Sept 26 1864

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	0	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) ?
(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Roger Robinson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Sarah Anne Leonard
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant W. M. Warman M. D.
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1930, to Oct 6, 1930,
that I last saw h[illegible]alive on Oct 6, 1930,
and that death occurred, on the date stated above, at 6 50 P. m.

The CAUSE OF DEATH* was as follows:
Hypertensive cardio-vascular renal disease (duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Lobar pneumonia 12 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Heart + kidneys
(Signed) J. J. Leyko, M. D.
10/6, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine
20 UNDERTAKER J. M. Cook
DATE OF BURIAL 10/9 19 30
ADDRESS 1217 E Pratt St

1930 C. HARRISON JONES, M. D.

Spec.—8-16-29—L. F. S.—100 Blks.

E 61148

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61148

CERTIFICATE OF DEATH

REGISTERED NO. 24-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1021 Vine St. (WARD) 18-7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lorenzo Winder

(a) RESIDENCE NO. 1021 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Col. | 5 Single, Married, Widowed, or Divorced. (write the word): Wdr

6 If married, widowed, or divorced
BUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Yd 01

(c) Name of employer Md.

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Peter Jones

(Address) 1514 Vine

15 Filed OCT 7 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 '30

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 '30, to Oct 5, 19 30,

that I last saw h alive on Oct. 4, 19 30

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of No

Was there an autopsy?

What test confirmed diagnosis? H Hozwood

(Signed) M. D.

Oct 6 19 38 (Address) 93 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Oct 7, 1930

20 UNDERTAKER: Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

Spec.—1-30—M. & T.—250 Bks.

E 61149 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61149

CERTIFICATE OF DEATH. + 160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lydenham Hospital ST., 945 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Blackwell

(a) RESIDENCE NO. Ellicott City, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 19, 1930.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	0	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Ellicott City
(State or country) Maryland

10 NAME OF FATHER Carl Lawrence

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Blackwell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

4 Informant Miss Sister Nurse (S.V.M.H.)
(Address) 1601 N. Bolton St. Balto

5 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH 5

16 DATE OF DEATH (month, day, and year) Oct 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1930, to Oct 5, 1930,

that I last saw him alive on Oct 5, 1930,

and that death occurred, on the date stated above, at 8.45 p. m.

The CAUSE OF DEATH* was as follows:

Inanition - due to improper diet

(duration) yrs. mos 16 ds.

~~CONTRIBUTORY~~ (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ellicott City, Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. Peter Mravetz, M. D.

, 19 (Address) Lydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem DATE OF BURIAL Oct 7, 1930

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

OCT 7 1930 C. HAMPSON JONES, M.D.

Spec.—1-30—M. & T.—250 Bks.

E 61150 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61150

43

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 7-4 WARD)

2-FULL NAME Michael Pietrowski

(a) RESIDENCE NO. 1601 Eastern Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

6a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? H O

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Poland

PARENTS

10 NAME OF FATHER Andy Pietrowski

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Poland

12 MAIDEN NAME OF MOTHER Nastalia ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Poland

14 Informant Mrs. ?
(Address) Baltimore City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-30

17 I HEREBY CERTIFY, That I attended deceased from 3-14-, 1930, to 10-4-, 1930, that I last saw h[illegible] alive on 10-4-, 1930, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

I (a) Carcinoma of lower lip with local metastasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Fred M. Dunwald M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 10 7 1930

20 UNDERTAKER J. J. Gabey & Sons

ADDRESS 1310 Eight St

Spec.—1-30—M. & T.—250 Bks.

E 61151 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61151

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 E. Preston St. ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Irvin.

(a) RESIDENCE No. 1524 E. Preston St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Priscilla Irvin.

6 DATE OF BIRTH (month, day, and year) September 5. 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Robert Irvin.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. Priscilla Irvin.

(Address) 1524 E. Preston St.

15 Filed ....., 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6th. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 18th, 19.... to Oct 6th, 1930.

that I last saw h[illegible] alive on Oct 6th, 1930

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstical nephritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Oedema of the Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Taylor, M. D.

, 19 (Address) 119 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 9th 1930
20 UNDERTAKER	ADDRESS
Chas. P. Evans & Son	118 N. Milton Ave

Spec.—1-30—M. & T.—250 Bks

E 61152 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61152

CERTIFICATE OF DEATH. 118-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Shugars

(a) RESIDENCE NO. 403 N. Bruce St WARD 19-27

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Sept 29 1930

8 AGE: Years | Months: 2 | Days: 2 | If LESS than 1 day, ...hrs. or ....min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Albert M. Shugars

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Ruth Houck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Albert M. Shugars (Address) 330 Bruce St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Oct 6, 1930, that I last saw him alive on Oct 6, 1930, and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic gastro mesenteric ileus.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Acute Pulmonary edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 5 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wylie M Law, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hanbleton

DATE OF BURIAL: Oct 8 19 30

20 UNDERTAKER: Chenowith Son

ADDRESS: 345 Eutaw

Spec.—1-30—M. & T.—250 Bks

E 61153 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61153

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 1-3 WARD)

2-FULL NAME Anastasius Coroneos

(a) RESIDENCE NO. 102 Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margarete Coroneos

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE — Years: 68 — Months: unknown — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer): Employer

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Greece.

PARENTS

10 NAME OF FATHER: Nick Coroneos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Aspasia Coroneos 600 S. Linwood Ave

15 Filed, 1930, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Oct. 7, 1930, that I last saw h- alive on Oct. 7, 1930, and that death occurred, on the date stated above, at 1230 m.

The CAUSE OF DEATH* was as follows:

Cardio - vascular - renal disease

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary): Uraemia (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Yeager, M. D.

10/7, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Oct 9 1930

20 UNDERTAKER: Ehrenworth & Son — ADDRESS: 3617 Eastern Ave

Spec.—1-30—M. & T.—250 Bks

E 61154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-002 E 61154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 13-W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Keller.

(a) RESIDENCE NO. 3560 Poole St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6 If married, widowed, or divorced: HUSBAND of or) WIFE of Eliza Keller.

7 DATE OF BIRTH (month, day, and year) Dec 28 1879

8 AGE: 51 Years 10 | Months 9 | Days 9 | If LESS than 1 day, ... hrs. or ... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman in a cotton mill.

(b) General nature of industry, business, or establishment in which employed (or employer): 0816

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Keller.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliza Lovell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Hospital Records

15 Filed ..., 19... Registrar

C. HAMPSON JONES, M. D.

OCT 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1930, to Oct 7, 1930, that I last saw him alive on Oct 7, 1930, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) G. Bowyer Manderson, M. D.

Oct 7 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's, Hampden — DATE OF BURIAL: Oct 10 1930

20 UNDERTAKER: Ehrensworth & Son — ADDRESS: 3617 Chestnut Ave

Spec.—1-30—M. & T.—250 Bks.

E 61155

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61155

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. 13-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4138 Roland Ave ST., 13 WARD)

2-FULL NAME Avarilla Katherine Miller

(a) RESIDENCE NO. 4138 Roland Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin F. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Numbers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant F. A. Miller

(Address) 805 Madison Ave.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 30., to 10-6-, 19 30.

that I last saw h.er alive on 10-6-, 19 30,

and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Agranulocytosis = Hemiplegia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Karl Steinmueller, M. D.

10/7, 19 30 (Address) Municipal Auto Bureau

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Perryman (Harford Co.)

DATE OF BURIAL Oct. 9- 1930.

UNDERTAKER Horace F. Burgee

ADDRESS 3631 Falls Road

Spec.—1-30—M. & T.—250 Bks.

E 61156 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61156

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 S. Ann St. ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas N. Hopkins

(a) RESIDENCE NO. 127 S. Ann St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 12 1930

7 AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Nelson Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Piszkiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Nelson Hopkins

(Address) 127 S. Ann St.

15 Filed Oct 1930 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 7, 1930,

that I last saw h alive on Oct 7, 1930,

and that death occurred, on the date stated above, at 5 30 a.m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Ryan M. D.

Oct. 7 1930 (Address) 804 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Lawn DATE OF BURIAL Oct 8 1930

20 UNDERTAKER John M Weber 4 and Chester ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61157

CERTIFICATE OF DEATH

101-001

E 61157

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bute St Hosp St., 18-76 Ward)

2-FULL NAME Amanda Mack

(a) RESIDENCE NO. 117 N Luzerne St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A. Mack

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 65; Months; Days; IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Mrs Minnie Stepney
(Address) 117 N Luzerne St

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia following
Endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Benbow, M. D.

10-7-1930 (Address) 501 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: 10-9 1930

20 UNDERTAKER: John C. Miller

ADDRESS: 2435 E Monument

Important. See instructions on back of certificate.

pcd

Spec.—1-30—M. & T.—250 Blks

E 61158

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61158

CERTIFICATE OF DEATH.

14-001

1-PLACE OF DEATH Baltimore City Hospitals 16-68

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Austen

(a) RESIDENCE NO. 2019 W Lafayette Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Frances A. Austen

6 DATE OF BIRTH (month, day, and year) - - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) OHO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Austen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of
(Address) Balto. City Hospitals, M.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6-30

17 I HEREBY CERTIFY, That I attended deceased from 4-2-29, 19 ..... to 10-6-30, 19 .....

that I last saw h i m alive on 10-6-30, 19 .....

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum
With Hemiplegia
(duration) 1 1/2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? 1. Home ; 2. Hospital

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

10-7-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood Cem

DATE OF BURIAL 10/9 1930

20 UNDERTAKER J. F. Lahey & Sons

ADDRESS 131 Eighth St.

Spec.—1-30—M. & T.—250 Bks.

233090 E 61159

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61159

CERTIFICATE OF DEATH.

37-002

1-PLACE OF DEATH

20-70 REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. H. Rogers

(a) RESIDENCE NO. 614 Lynhurst ST., WARD D

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Catharine

6 DATE OF BIRTH (month, day, and year) Nov-16-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insur Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belair Md

12 MAIDEN NAME OF MOTHER Mary Creaghan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Belair Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed Oct 20 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-6-1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to Oct-6-1930, that I last saw h[illegible] alive on Oct-6-1930, and that death occurred, on the date stated above, at 705 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, generalized

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. R. Trimble M. D.

Oct6, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 10/9 1930

20 UNDERTAKER J. F. Hardesty & Sons

ADDRESS 13 E Biddle St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61160

CERTIFICATE OF DEATH

E 61160

REGISTERED NO. 44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 W Lafayett ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Eliza Keller (Auld)

(a) RESIDENCE NO. 1604 W. Lafayette St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Auld

7 DATE OF BIRTH (month, day, and year): Jan. 1 1877

8 AGE: Years 53 | Months 9 | Days 4 | If LESS than 1 day, ... hrs. or ... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

10 BIRTHPLACE (city or town) (State or country): Calvert Co. Md.

11 NAME OF FATHER: Friedland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Mar Kinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calv. Co. Md

Informant: Mrs Lena Eastburn

(Address) Woodbury Park. N.J.

Filed Oct 8 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4- 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29 1930, to Oct 4 1930, that I last saw h alive on Oct 4th 1930, and that death occurred, on the date stated above, at 4.50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma 6 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. E. Bell, M. D.

, 19 (Address) 713 N. Eutaw St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Oct 8 1930

20 UNDERTAKER: John H Trader

ADDRESS 1027 Hand Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61161

CERTIFICATE OF DEATH

188-Y03E 61161

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 7-31 Ward)

2-FULL NAME Middleton Scott

(a) RESIDENCE NO. 911 E. Fremont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Paul Fletcher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Bostic

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N C

14 Informant Francis Harris
(Address) 911 Fremont Ave

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Fract Skull knocked down by motor auto

(b) ..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract Skull

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted, if not at place of death? Hamburg St Bridge

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Frame, M. D.

10/6 1930 (Address) 2931 W. Eddy

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Oct. 8 1930

20 UNDERTAKER John H. Trader — ADDRESS 1027 Hanover

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

61162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 V

E 61162

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3546 S. Hanover St. 25-7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Sass

(a) RESIDENCE NO. 3546 S. Hanover ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: William Sass

6 DATE OF BIRTH (month, day, and year): Sept 3rd 1848

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
82	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Inaya Rushnle 3546 Hanover St

15 Filed 10/6, 1930 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5th 1930

17 I HEREBY CERTIFY, That I attended ~~deceased~~ from Sept 17th, 1930, to Oct 5th, 1930, that I last saw ~~her~~ alive on Oct 4th, 1930 and that death occurred, on the date stated above, at 6 15 a.m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency of heart, chronic myocarditis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) — yrs. — mos. 18 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Henry Lecile, M. D.

(Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: Oct 8th 1930

20 UNDERTAKER: E Schloman & Son

ADDRESS 1057 Hanover

Spec.—1-10-21—M&T—1500 Bks.

E 61163

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

101-001 E 61163

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 131 N. Streeper ST.) 6-11 (WARD)

2-FULL NAME Jacob Senker

(a) RESIDENCE NO. 131 N. Streeper ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Catherine Senker

6 DATE OF BIRTH (month, day, and year) 8-10-76

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer): 185

(c) Name of employer: Penny Mfg Co. Baltimore

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Peter Senker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs. Catherine Senker 131 N. Streeper

15 Filed ..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Oct 5, 1930, that I last saw h(M)alive on Oct 4, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Cushman M. D.

Oct 7, 1930 (Address) 3100 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 10-8-30

20 UNDERTAKER: W. E. Humphrey Co — ADDRESS 2410 E. ...

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61164 — 100-001 ✓ — E 61164

CERTIFICATE OF DEATH

REGISTERED NO. 12-50

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 314 Whitridge Ave ST., 12 WARD

2—FULL NAME Thomas B. Johnson

(a) RESIDENCE NO. 314 Whitridge Ave ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Ella G Johnson

6 DATE OF BIRTH (month, day, and year): Feb. 1860

7 AGE: Years 70 | Months 7 8 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:
(a) Trade, profession or particular kind of work: Dynamite Concussion
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Howard Co

PARENTS

10 NAME OF FATHER: Edward J Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Estella Harding

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robt Johnson
(Address) 314 Whitridge ave

15 Filed 1930 — HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1930, to Oct 6, 1930, that I last saw h[illegible] alive on Oct 6, 1930, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) Arterio sclerosis
(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M.D.
10-8, 1930 (Address) 2858 Hayford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Oct 9 1930

20 UNDERTAKER: A. S. Marshall — ADDRESS: 3539 Fall Rd

Spec.—1-12-23—31&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1165

CERTIFICATE OF DEATH.

90 C 61165

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 670 W. Fairmont ~~Ave~~ St. WARD 25)

2-FULL NAME Mamie Poach (Mack)

(a) RESIDENCE NO. 670 W. Fairmont St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilson Poach

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 57 Months — Days — If LESS than 1 day, hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: Fannie Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Fannie Travers

(Address) 1733 Madison Ave.

15 Filed 8-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1st, 1930, to Oct. 6th, 1930, that I last saw h alive on Oct. 6th, 1930 and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Lincoln Shelton M. D.

10/7/1930 (Address) 1203 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery

DATE OF BURIAL: Oct 9, 1930

20 UNDERTAKER: Mr. Katie R. Williams

ADDRESS 3224 Schroeder St.

Spec.—1-30—M. & T.—250 Bks.

E 24132d

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61166

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 19-27 WARD)

2-FULL NAME Catharine Schlarb

(a) RESIDENCE No. 301 N Fulton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: William

6 DATE OF BIRTH (month, day, and year): Jan 13/72

7 AGE — Years: 58 — Months: 8 — Days: 23 — If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: N W.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: William

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catharine Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 1930 — C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct-6-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1930, to Oct 6, 1930, that I last saw her alive on Oct 6, 1930, and that death occurred, on the date stated above, at 11 05 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Myocardial insufficiency

(duration) yrs. mos ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Confirmed by autopsy

(Signed) Caroline C. Bedell, M. D.

10-7-1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Oct 10 1930

20 UNDERTAKER: Jeremiah Taylor — ADDRESS: 1600 N Monroe

Spec.—1-30—M. & T.—250 Bks. Dr. Street 445-Fort Ave South 0557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61167 113 E 61167

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1321 Cooksie ST. 24-35 WARD)

2-FULL NAME Gunter-Schweingruber

(a) RESIDENCE NO. 1321 Cooksie ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Erich Schweingruber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Bruns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Erich Schweingruber

(Address) 1321 Cooksie St

15 Filed 8-1930 19 H. LEON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1930, to Oct 7, 1930, that I last saw h.... alive on Oct 7, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) Sidney N. Truitt, M. D.

10/7, 1930 (Address) 456 E Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 10/9/1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61168

E 61168

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1835 W. Fayette ST. 19-27 (WARD)

2-FULL NAME Lydia A. Bothwell

(a) RESIDENCE NO 1835 W. Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fmale.	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt Bothwell

6 DATE OF BIRTH (month, day, and year) Nov 2 / 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	56	11	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Wm Rettan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER — Lavin

13 BIRTHPLACE OF MOTHER (city or town) Ontario (State or country)

14 Informant Robt. Bothwell

(Address) 1835 W. Fayette

15 Filed ... 1930 C. 192 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Brook M. D. Coroner

Oct 8 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sarnia, Ont. Canada

DATE OF BURIAL 10/9 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 Pine St

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61169 — 118 E 61169 — 001

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Linden & Madison ST. 12-51 WARD)

2—FULL NAME Mrs Amanda Warner

(a) RESIDENCE NO. 2826 Huntingdon ave ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	white	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. E Warner

7 DATE OF BIRTH (month, day, and year) June 30 1874

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Emanuel Bellinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md (?)

12 MAIDEN NAME OF MOTHER Elizabeth Wineberg

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country)

14 Informant Jas. E. Warner

(Address) 2826 Huntingdon ave

15 Filed 10-8-1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 7, 1930, that I last saw her alive on Oct 7, 1930, 11-25 A m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Ventral Hernia

(duration) 1 yrs. 4 mos. ds.

Pneumonia Bilateral

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home + Hospital

Did an operation precede death? Yes Date of Oct 7, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert H. Clements M. D.

Oct 17, 1930 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL German Reformed Cem Manchester Md — DATE OF BURIAL Oct 10, 1930

20 UNDERTAKER J. Walter Davis 3418 Gertrude ave — ADDRESS

Spec.—1-30—M. & T.—250 Bks.

61170

HEALTH DEPARTMENT—CITY OF BALTIMORE

E-61170

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Edward Crist

(a) RESIDENCE NO Columbia, Penn. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

6a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of or) ~~WIFE~~ of Ida Crist

6 DATE OF BIRTH (month, day, and year) Dec. 1, 1860

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	69	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Editor + Publisher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ill.

PARENTS

10 NAME OF FATHER: Samuel Crist

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn.

12 MAIDEN NAME OF MOTHER: Katherine Cleaverstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn.

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HARRIS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1930, to Oct. 7, 1930, that I last saw him alive on Oct. 7, 1930, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder.

(duration) 2+ yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage.

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/6/30

Was there an autopsy? Yes

What test confirmed diagnosis? Surgical exam, Operative Exam

(Signed) Lloyd T. Nevin, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbia Pa — DATE OF BURIAL: 9/8/31

20 UNDERTAKER: Joseph Adams — ADDRESS: 221 Berg

Spec.—1-10-21—M&T—1500 Bks.

61171 61171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST. 25-80 WARD) 25-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward P. O'Dea

(a) RESIDENCE NO. Brooklyn N. Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1909

7 AGE — Years: 20 — Months: 11 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brookland N. Y.

PARENTS

10 NAME OF FATHER: Patrick O'Dea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elinor Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Elinor O'Dea (Address) Brooklyn N. Y.

15 Filed OCT 8 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-24, 1930, to 10-7, 1930, that I last saw h— alive on 10-7, 1930, and that death occurred, on the date stated above, at 10 20 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Emmitsburg Md.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Widal test

(Signed) Nicholas E. Donelan M.D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooklyn N. Y.

DATE OF BURIAL: Oct. 8, 1930.

20 UNDERTAKER: Martin Fahey & Sons

ADDRESS: 1827 N. North Ave

Spec.—1-30—M. & T.—250 Bks.

E 61172

E/61172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1014 Hillman ST. 10-1 WARD)

2-FULL NAME John P. Donovan

(a) RESIDENCE NO. 1014 Hillman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth E. Donovan nee Hassett

6 DATE OF BIRTH (month, day, and year) Feb. 18. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7	20	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work District Supt.

(b) General nature of industry, business, or establishment in which employed (or employer) City Street 86

(c) Name of employer Cleaning Dept.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William J. Donovan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Kilben

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Elizabeth E. Donovan
(Address) 1014 Hillman St.

15 Filed OCT 8 - 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7. 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/17, 1930, to 10/7, 1930, that I last saw h— alive on 10/6, 1930, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis, Hypertension Angina Pectoris

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Reginald Hess M. D.

10/8, 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Oct 10 1930

20 UNDERTAKER Elmer W. Castelin

ADDRESS 524 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 61173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 61173

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 20 Aisquith ST. 10-14 WARD)

2—FULL NAME Sr. M. Illuminata Mary Fraher

(a) RESIDENCE NO. Convent of Notre Dame ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20, 1857

AGE 73 Years	Months 6	Days 17	If LESS than 1 day, ...hrs. or ....min.

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

8 BIRTHPLACE (city or town) Philadelphia Pa.
(State or country)

10 NAME OF FATHER Joseph Fraher

11 BIRTHPLACE OF FATHER (city or town) Philadelphia Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Chat. Hupp

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Philadelphia Pa.

14 Informant Sr. M. Notre Dame

(Address)

Filed OCT 8 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1930, to October 6, 1930, that I last saw h e alive on October 6, 1930, and that death occurred, on the date stated above, at 11:30 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uremia

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual ones

(Signed) L. J. Kirby, M. D.

Oct 9, 1930 (Address) 110 E. Northern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notch Cliff Md.	Oct 9 1930
20 UNDERTAKER Frank A. Fink	ADDRESS 910 N. Gay St

Spec.—1-30—M. & T.—250 Bks

E 61174 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61174

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Kenwood Ave. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Letterer

(a) RESIDENCE NO. 134 N. Kenwood Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Letterer

6 DATE OF BIRTH (month, day, and year) Apr 9. 1846

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	5	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Louis Meder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M. Gardner

(Address) 134 N. Kenwood Ave

15 Filed OCT 8 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6/30.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct 6, 1930

that I last saw h[illegible] alive on Oct 6, 1930

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Dementia Senilis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cardiac Obesity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) [illegible] M. D.

Oct 8 1930 (Address) 800 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Oct 9 1930.

20 UNDERTAKER Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette

Spec.—1-30—M. & T.—250 Bks

E 61175 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61175

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33d Calvert ST.) 27-44 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Simon

(a) RESIDENCE NO. 4911 Arabia Ave., Hamilton, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs E. A. Simon

6 DATE OF BIRTH (month, day, and year) April 5 - 1884

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

FILED OCT 8 - 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1930, to Oct. 8, 1930, that I last saw him alive on Oct. 8, 1930, and that death occurred, on the date stated above, at 12:35 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 4911 Arabia Ave.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Spinal Fluid Exam

(Signed) Francis W. Clinch, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 10-11 1930

UNDERTAKER

ADDRESS 408 Eutaw

Spec.—1-30—M. & T.—250 Bks

E 61176 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61176

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH Mercy Hospital REGISTERED NO. 27-44

CITY OF BALTIMORE: (No. ... St. ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ruck

(a) RESIDENCE NO. 2816 Grindon Ave ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND) of ~~or WIFE~~ of Mary

6 DATE OF BIRTH (month, day, and year) May 5 - 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Ruck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant J. J. Smith M. D.
(Address)

15 Filed ... 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Oct 7, 1930, that I last saw him alive on Oct 7, 1930, and that death occurred, on the date stated above, at 8^10 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio-Vascular Disease

Unknown (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocardial Failure

Unknown (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. J. Leyko, M. D.

, 19 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 10-10 1930

20 UNDERTAKER J. Rush

ADDRESS 660 Sutton

Spec.—9 30—A. & Co.—250 Bks.

E 61177

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61177

CERTIFICATE OF DEATH

124

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 516 So Lakewood Ave. ST. 1-3 WARD)

2-FULL NAME Alexander William Jones

(a) RESIDENCE NO. 516 So Lakewood Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and state)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Minnie Jones

6 DATE OF BIRTH (month, day, and year) Oct 24 1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Eugene Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Anna Williamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss. Grace Jones (Daughter)
(Address) 516 S. Lakewood Ave.

15 [illegible] Registrar

8 - 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6-1930

17

I HEREBY CERTIFY, That I attended deceased from Sept 11 1930, to October 6 1930

That I last saw h~~im~~ alive on October 4 1930

and that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis & Cholecystitis

(duration) about yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Jr. Cliff M. D.

Oct 7. 1930 (Address) 3532 Chestnut Ave

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Oct. 9 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St. & Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

E 61178

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61178

CERTIFICATE OF DEATH.

47

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2406 Annapolis St., 16-6 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Roether

(a) Residence No. 2406 Annapolis St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female | 4-COLOR OR RACE, W | 5-Single, Married, Widowed, or Divorced, (Write the word) Married

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Roether

6-DATE OF BIRTH (month, day and year) July 14-1878

7-AGE 52 yrs. 2 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Boston Md

PARENTS

10-NAME OF FATHER, Peter J. Steckmeyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Alsace France

12-MAIDEN NAME OF MOTHER, Clementine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-(Informant) Wm. H. Roether

(Address) 2406 Annapolis Ave

15-FILED 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/7/30

17- I HEREBY CERTIFY, That I attended deceased from May 1 1930 to Oct. 7 1930

that I last saw h[illegible] alive on 10/7 1930

and that death occurred, on the date stated above, at 10. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Spinal Column Lumbar Vertebrae

Carcinoma of Left Breast

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Embolism Pulmonary (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of May 1928

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X Ray

(Signed) J. H. Chaney M.D.

1930 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. 10/10/30

20-UNDERTAKER. H. Brauning Son

ADDRESS 1136 Gorsuch Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61179

CERTIFICATE OF DEATH

90 E 61179

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3000 (ST.) Guilford Ave (WARD) 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis F. Glantz

(a) RESIDENCE NO. 3000 (ST.) Guilford Ave (WARD) 12

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ~~8~~ mos. ~~6~~ ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Feb. 7-1856

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8.		

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retail business

(c) Name of employer (Leather)

9 BIRTHPLACE (city or town) (State or country) D. C.

PARENTS

10 NAME OF FATHER Christian Glantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Strobler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hiram A. Glantz

(Address) 1846 N. Chester St.

15 - 1930 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1928, to Oct 7, 1930, that I last saw him alive on Oct. 6, 1930 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Stethascope.

(Signed) Frank A. Glantz, M. D.

Oct 8, 1930 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Oct 9 1930
20 UNDERTAKER N. J. Marshall	ADDRESS 3639 Falls Rd.

Spec.—1-30—M. & T.—250 Bks

E 61130 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 74 E 61130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 19-27 ST. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret McConnell

(a) RESIDENCE NO. 125 N. Fulton Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Thomas J.

6 DATE OF BIRTH (month, day, and year) Mar. 8, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER William Saunders

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Christopher

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed 10-8-30, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8-30

17 I HEREBY CERTIFY, That I attended deceased from 9-29-30, 19 to 10-8-30, 19
that I last saw her alive on 10-8-30, 19
and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:

Thrombosis, middle cerebral artery, right.

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Unknown.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? yes.
What test confirmed diagnosis? Autopsy.

(Signed) Paul Podgel, M. D.
(Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hurlock Md. DATE OF BURIAL Oct 10 1930

20 UNDERTAKER John C. Butler 2nd ADDRESS 855 Edison

Spec.—1-30—M. & T.—250 Bks.

E 61181

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61181

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Patapsco ST. 23-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathias Gimbel

(a) RESIDENCE NO. 1107 S Patapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Katherine Gimbel

6 DATE OF BIRTH (month, day, and year) Oct 20, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	58	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Basket Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Mathias Gimbel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Mrs. Lili

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Miss Katherine Gimbel

(Address) 1107 Patapsco St.

15 [illegible] 19 C. HARRISON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1930 to October 7, 1930.

that I last saw him alive on October 6th, 1930.

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Endocarditis & Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John C. Schwenck, M. D.

19 (Address) 1334 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Oct 10 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

1-30—M. & T.—100 B—50L

E 61182

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 61182

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp ST. 11-59 WARD

2-FULL NAME Isadore Friedman

(a) RESIDENCE NO. 2213 Penna Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Friedman

6 DATE OF BIRTH (month, day, and year) 1892.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoe maker
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Friedman

11 BIRTHPLACE OF FATHER (city or town) Russia. (State or country)

12 MAIDEN NAME OF MOTHER Rebecca

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Sarah Friedman

(Address) 2213 Penna Ave

15 Filed OCT 9 1930

C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to her death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. Leland Hollick Coroner, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levy Meyerberg Lyn

DATE OF BURIAL 10-9-1930

20 UNDERTAKER Jac Levin, 1731 E Balto St

ADDRESS

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61183 32 E 61183

1-PLACE OF DEATH

CITY (or) BALTIMORE: (No.) Sinai Hospital ST., 27-55 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Sevel

(a) RESIDENCE NO 3400 Avondale Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Reba Sevel

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Benj. Sevel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Balto., St

15 Filed 9-[illegible]-1930 G. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis (tubercular)

..... (duration) yrs. ..... mos 20 ds.

CONTRIBUTORY (Secondary) Reported Inactive Pulmonary

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Baum, M. D. Coroner

10/7/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Park Road

DATE OF BURIAL 10-9- 1930

20 UNDERTAKER Jacob Lewis

ADDRESS 1439 E Balto St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61134 — 90 — E 61134

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Home for Aged & Infirm

CITY OF BALTIMORE: (No. Belvedere & Greenspring ST. 27-54 WARD

2-FULL NAME Victor Sher

(a) RESIDENCE NO. Greenspring & Belvedere ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs ... mos ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: White male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Ida

6 DATE OF BIRTH (month, day, and year): 1833

7 AGE: 97

Years	Months	Days	If LESS than 1 day, hrs or min.
	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Sigmund Shulman, Belvedere & Greenspring

15 Filed 9-1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-7-1930

17 I HEREBY CERTIFY, That I attended deceased from 5-16, 1930, to 10-7, 1930, that I last saw h[im] alive on 10-7, 1930, and that death occurred, on the date stated above, at 7 55 m

The CAUSE OF DEATH* was as follows:

Chr. valvular heart disease

(duration) 10 yrs mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) A Edmund Cohen, M. D.

10/7 1930 (Address) Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rest. Rosedale Cmty

DATE OF BURIAL: Oct 9 1930

20 UNDERTAKER: L. Levinson & Bro

ADDRESS 1127 E Balto st

Spec.—2-29-28—L. F. S.—500 Blks.

61135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 61135

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1617 E Lombard ST. 3-4 WARD)

2—FULL NAME Gedalia Haffman

(a) RESIDENCE NO. 1617 E Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rebecca

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Azer Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Katz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Albert Hoffman

(Address) 1617 E Lombard St.

15 DATE RECEIVED OCT 9 - 1930

HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1930, to Oct 7th, 1930

that I last saw him alive on , 1930

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) chronic nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Libman, M. D.

10-8, 1930 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern ave	Oct 9 1930
20 UNDERTAKER	ADDRESS
J. Herman Bro	1127 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61186 — 167-002 — E 61186

CERTIFICATE OF DEATH.

REGISTERED NO. 27-43

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Raspeburg Maternity Hospital, 5801 Belair Rd., Raspeburg ST. 26th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Newborn Infant of Frank and Paula Knaack

(a) RESIDENCE NO. 5020 Catalpha Rd., Hamilton, Md. ST., 27th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1930

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or 50 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Knaack
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER Paula Wilst
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Frank Knaack
(Address) 5020 Catalpha Rd., Hamilton, Md.

15 Filed 10-1930 G. HAMILTON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from From birth, 19 , to Oct. 8, 1930,
that I last saw her alive on Oct. 8, 1930,
and that death occurred, on the date stated above, at 9.50A. m.

The CAUSE OF DEATH* was as follows:

Paralysis of respiratory muscles due to birth trauma. Breech birth with arrested after-coming head.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Morris B. Green M. D.
Morris B. Green,
10/8, 1930 (Address) Harford Rd. & Evergreen Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 9 1930

20 UNDERTAKER: Frederick Lasahn Sons — ADDRESS: 7401 Belair Rd

Spec.—1-30—M. & T.—250: Bks.

61187

HEALTH DEPARTMENT—CITY OF BALTIMORE

61187

36-003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 19-27 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Gross

(a) RESIDENCE NO. 1612 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Hilda Gross.

6 DATE OF BIRTH (month, day, and year) Jan 25, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
23	—	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md.

PARENTS

10 NAME OF FATHER Benjamin Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Daisy Blackstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ..... (Address) Balto City Hosp

15 Filed ..... 19 ..... Registrar

HAMPSON JONES, M. D.

OCT 9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7-30

17 I HEREBY CERTIFY, That I attended deceased from 10-1- , 1930, to 10-7- , 1930, that I last saw h... alive on 10-7- , 1930, and that death occurred, on the date stated above, at 10¼ A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Suppurative Purulent adenitis

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of .....

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy findings

(Signed) Fred M. Dunbar, M. D.

, 19 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edmondson Ave

DATE OF BURIAL 10-9 1930

20 UNDERTAKER Dent Eaton

ADDRESS 916 Bo ave

1-30—M. & T.—100 B—50L

E 61138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 61138

REGISTERED NO. .....

(If death occurred in a hospital or institution, give NAME instead of street address and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp. ST.) 11-24 (WARD)

2-FULL NAME Shirley Davis

(a) RESIDENCE NO 1320 Mc Culloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: N D

6 DATE OF BIRTH (month, day, and year): Nov 10 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Jas Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Minnie Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Jas Lewis

(Address) 1320 Mc Culloh St

Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8th at 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. Hampson Jones, M. D. Coroner

19 ..... (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 10-9 1930

20 UNDERTAKER: Dennis Corbin

ADDRESS 916 Eutaw

OCT 9 - 1930 H. HAMPSON JONES, M. D. Registrar

Spec.—1-30—M. & T.—250 Bks.

E 61189 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61189

CERTIFICATE OF DEATH.

REGISTERED NO. 101001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1416 W. Lanvale ST., 14-27 WARD)

2-FULL NAME Sarah R. Talbot

(a) RESIDENCE No. 1307 W. mulberry ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): W

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Joseph P. Talbot

6 DATE OF BIRTH (month, day, and year): Aug 14 1858

7 AGE: Years 71; Months 1; Days 28; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Ont

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edna Richardson

(Address) 1307 W. mulberry St

15 Filed ....., 19..... C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1930, to Oct. 8, 1930, that I last saw h[illegible] alive on Oct 8, 1930, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Pigott, M. D.

10/8, 1930 (Address) 1536 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Oct. 10 1930

20 UNDERTAKER: Chas. H. Ahrens Son — ADDRESS: 1400 Madison

Spec.—1-30—M. & T.—250 Bks

E 61190

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61190

16-002

CERTIFICATE OF DEATH.

REGISTERED NO. 26-37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 So Conkling St.) ST. 26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Linz.

(a) RESIDENCE No. 828 So Conkling St ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Dec 24 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Sebastain J Linz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Theresa Kresslei

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Sebastain Linz Father

(Address) 828 so Conkling St

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

Reg. 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 6, 1930,

that I last saw h.... alive on ....., 19....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Dysentery Bacillary

(duration) ....yrs. ....mos 6 da.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) ....yrs. ....mos. 1 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilton, M. D.

10/6, 1930 (Address) 314 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Hearts Cemetery,

DATE OF BURIAL Oct 9 19 30

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 So. Wolfe St.

Spec.—1-30—M. & T.—250 Bks.

E 61191 HEALTH DEPARTMENT—CITY OF BALTIMORE 46 E 61191

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 N Kenwood Ave ST. 6-10 WARD)

2-FULL NAME Johanna Albrecht

(a) RESIDENCE NO. 138 N Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Chas F. Albrecht

7 DATE OF BIRTH (month, day, and year): Mar 19-1859

8 AGE: Years 71; Months 6; Days 20; If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

10 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Geo Strohmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary DeReis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr Geo Albrecht

(Address) 138 N Kenwood Ave

15 Filed 9-1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8-1930

17 I HEREBY CERTIFY, That I attended deceased from June 19, 19 29, to Oct 10, 19 30,

that I last saw h[illegible] alive on Oct 7, 19 30,

and that death occurred, on the date stated above, at 3 20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

Metastasis Rectum

(duration) 1 yrs. 4 mos [illegible] ds.

CONTRIBUTORY (Secondary) Acute Metastasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C N Meyer M. D.

10/8, 19 (Address) 1520 E. 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 10 1930

20 UNDERTAKER: John Ulrich — ADDRESS: 2008 Aliceanna

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 VE 61192

61192

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 716 N. Durham ST. 7-9 WARD)

2-FULL NAME Mary Foster

(a) RESIDENCE NO 716 N. Durham ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dennard Foster

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	6 mo		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co., Md.

PARENTS

10 NAME OF FATHER John Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lovie Travers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Dennard Foster
(Address) 716 N. Durham St

15 Filed OCT 9 1930 No. 2 Post

HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Cardio- Vascular Disease

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Information given

(Signed) ..... Coroner, M. D.
Oct 8/30
(Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL 10-10 1930

ADDRESS

20 UNDERTAKER Jas. In. Simms 1623 E. Madison st

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61193 × 89 E 61193

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH: Arundal Hotel.

City of Baltimore: (No. Charles & Mount Royal Ave. St., 11-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Francis E.O'Hara.

(a) RESIDENCE NO. Watertown.N.Y. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced, HUSBAND of [redacted] Carmelia O'Hara.

6 DATE OF BIRTH (month, day, and year) April 7th 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	56	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Commision business.
(b) General nature of industry, business, or establishment in which employed (or employer): Produce.
(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn.N.Y.
(State or country)

PARENTS

10 NAME OF FATHER W James F.O'Hara.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Carmelia O'Hara.(wife.
(Address) 631 Coffen St.Watertown N.Y.

15 Filed OCT 9-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9,1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto W Leonhard, M. D.

10/9. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: North Watertown Cemetery Watertown N.Y.

DATE OF BURIAL 10/9 1930

20 UNDERTAKER Chas. P. Trawl & Son

ADDRESS 1800 N. Mount Royal Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 61194

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61194

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE, (No.) 1208 Ensor ST. 10-14 WARD)

2-FULL NAME Teresa M. Maas

(a) RESIDENCE NO. 1208 Ensor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 6 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	6	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Bernard H. Maas

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Mary B. Hatchkow

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mr. Bernard H. Maas
(Address) 1208 Ensor St

15 Filed 10-9-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1930, to Oct. 7, 1930, that I last saw h[illegible] alive on Oct. 7 1930, and that death occurred, on the date stated above, at 12 21 P. m.

The CAUSE OF DEATH* was as follows:
Adenocarcinoma of tubes
Mets uterus

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Pertonea Infestans
(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of Sept. 13-1930.
Was there an autopsy? yes
What test confirmed diagnosis? Operation & Pathology test
(Signed) Benj. S. Hampton M. D.
10/9 1930 (Address) 1716 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Oct. 11 1930

20 UNDERTAKER Henry Heck Sons, Inc. ADDRESS 1301 E Eager St

Spec.—1-30—M. & T.—250 Bks.

E 61195 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61195

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH
CITY OF BALTIMORE; (No.) 613 S. Curley St. 1-3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline J. Dean

(a) RESIDENCE NO. 613 S. Curley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) May 11 1910

8 AGE: Years 20; Months 4; Days 27; If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: A. F. Johnson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Katherine Zintanf
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. A. F. Johnson
(Address) 613 S. Curley St

15 Filed 9-1930 By HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct 8, 1930, that I last saw her alive on Oct 7, 1930, and that death occurred, on the date stated above, at 9:15 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous of Lungs

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary): Hemorrhage of Lung
(duration) Subout 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Observation

(Signed) Horace B. Silver, M. D.
10/5, 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct. 11 1930

20 UNDERTAKER: Henry Hoelle Sons, Inc. — ADDRESS: 1301 E Eager St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61196

41-002

E 61196

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME James McDonnada

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6b DATE OF BIRTH (month, day, and year) Dec. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	69	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick McDonnada

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Preston & Valley Sts

15 Filed 6 130 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9/30.

17 I HEREBY CERTIFY, That I attended deceased from 10/2, 1930, to 10/9, 1930, that I last saw h— alive on 10/9, 19....., and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Hemorrhage (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wall, M. D.

10/5, 1930 (Address) 1216 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cem.	11 1930
20 UNDERTAKER	ADDRESS
Wm Cook	117 2d Ave

Spec.—1-30—M. & T.—250 Bks

E 61197 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61197

CERTIFICATE OF DEATH.

REGISTERED NO. 100

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hosp. ST. H-25 WARD)

2-FULL NAME Samuel Langerman

(a) RESIDENCE NO. 612 W Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Investment

(b) General nature of Industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Trenton N.J.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant University Hosp. (Records) (Address)

15 Filed OCT 9 - 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 9, 1930, that I last saw h alive on Oct 1, 1930, and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Hypernephroma Right Adrenal gland

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 22, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Gross examination

(Signed) J R Heuschman, M. D.

(Address) University, Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila. Pa DATE OF BURIAL Oct. 9 1930

UNDERTAKER Margaret R. Flynn ADDRESS 1422 Light St.

1-30—M. & T.—100 B—50L

E 61198 E 61198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 198

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hos St. 16-68 WARD)

2-FULL NAME Elias H. Flender

(a) RESIDENCE NO Glen Morris Md ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 [illegible], Married, [illegible]ed, or Divorced (write the word) M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma H Flender

6 DATE OF BIRTH (month, day, and year) Sept 2 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	0	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Richard H Flender

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Francis Eckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Richard H Flender

(Address) Cockeysville Md

Filed OCT 5 - 1930, 192 C. HAMPSON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows (Homicide)
Hemorrhage due to Incised wound of neck.
(duration) ..... yrs. ..... mos. Short

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Near Rogues Rd Reisterstown Md

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) H. Leslie Hollyday, M. D.
Coroner
(Address) Towson Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL All Saints Cemetery

DATE OF BURIAL Oct 10 1930

ADDRESS .....

20 UNDERTAKER J F Edens Reisterstown Md

1-30—M. & T.—100 B—50L

E 61199

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61199

CERTIFICATE OF DEATH

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. Beere

(a) RESIDENCE NO 2033. E. Preston St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel (Ogle) Beere

6 DATE OF BIRTH (month, day, and year) Jan 20/1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lumber Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto/. Md.

PARENTS

10 NAME OF FATHER Michael Beere

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Closley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. James J. Beere

(Address) 2033 E. Preston St

15 Filed Oct 9 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos ds.

Probably Ruptured Appendix

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Jos. H. Allen, M. D. Coroner

Oct 9/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Oct 11, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto

Cor.—10-10-29—A Co.—100 Bks.

(Brady)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61200

179 E 61200

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Duker Pl

City of Baltimore: (No. 1442 Duker Pl St. 1-V Ward)

2-FULL NAME James Brady

(a) RESIDENCE NO. 102 Rochester Pl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Mal	colrd	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Brady

6 DATE OF BIRTH (month, day, and year) June 17 1878 ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	51	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Longshoreman
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Brady

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown McFaul

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant (Address) Mary Brady 102 Rochester

15 Filed ..... 19 .... C. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism on chronic nephritis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fowler M. D.

(Address) 700 E Chase St Oct 9 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem	10/11/1930
20 UNDERTAKER	ADDRESS
Harry A Weitzel	1501 Edmondson Ave

Important. See instructions on back of certificate.

9 - 1930

pec.—2-29-28—L. F. S.—500 Bks.

Yewell

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

80 E 61201

E 61201

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 N. Fort Ave. ST. 04-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kenneth W. Yewell

(a) RESIDENCE NO. 906 N. Fort Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant.

3 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Jan. 26, 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8,	12.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. NO

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James W. Yewell.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lorraine Roby.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant James W. Yewell.
(Address) 906 N. Fort ave.

15 1930 C. HAMPSON JONES, M. D. Registrar
Dep. MCX

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/8, 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/7, 1930, to 10/8, 1930,
that I last saw h[illegible] alive on 10/8, 1930
and that death occurred, on the date stated above, at 4, a m.

The CAUSE OF DEATH* was as follows:

Convulsions

5 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suffering from

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Turlington, M. D.

, 19 (Address) 2102 Mt Holly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL 10/10, 1930

20 UNDERTAKER H. Howard Evans ADDRESS 38 E Fallsway

Spec.—1-30—M. & T.—250 Bks.

E 61202

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 61202

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (a) Baltimore City Hosp. (b) 21-29 (ST. AND WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Ruston LaBar

(a) RESIDENCE NO. 1122 Sargent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown 1854

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Maker

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant ?

(Address) Baltimore City Hosp.

Filed 9-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8-30

17 I HEREBY CERTIFY, That I attended deceased from 1-5-, 1925 to 10-8-, 1930,

that I last saw h...alive on 10-8-, 1930,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis

(duration) Uncertain

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings

(Signed) Fred M. Butterworth, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additions) space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 10/10/1930

20 UNDERTAKER John J. Cowan & Son — ADDRESS 901 Edmondson Ave.

Spec.—1-30—M. & T.—250 Bks.

240576 E 61203

HEALTH DEPARTMENT—CITY OF BALTIMORE E 61203

CERTIFICATE OF DEATH. + 100-601

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 79 WARD)

2-FULL NAME Frederick Geddes

(a) RESIDENCE NO. 2116 Parkwood Ave ST., WARD Toledo Ohio
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Kate Geddes

7 DATE OF BIRTH (month, day, and year): Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mich.

PARENTS

10 NAME OF FATHER: Norman Geddes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Laura Casey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 1930 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct-9-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Oct-9, 1930, that I last saw him alive on Oct-9, 1930, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/6/30

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Signs, P.M. findings

(Signed) Lloyd V. Lewis M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Toledo, Ohio — DATE OF BURIAL: Oct 9 1930

20 UNDERTAKER: Hughes & Jones Inc — ADDRESS: 1711 Broadway

Spec.—1-30—M. & T.—250 Bks.

E 61204

E 61204

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2-4 WARD)

2-FULL NAME James Edwards

(a) RESIDENCE No. 112 S. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Infant

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 30 - 1929

7 AGE — Years | Months: 11 | Days: 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: James Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Madelene Briggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Cousin

(Address) JOHNS HOPKINS HOSPITAL

Filed Oct 11 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-9-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-3, 1930, to Oct-9, 1930, that I last saw h[illegible] alive on Oct-9, 1930, and that death occurred, on the date stated above, at 9 20 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery, Ac. Bacillary

(duration) 4 weeks yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Margadant, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dolly Kedemer — DATE OF BURIAL: Oct 11 1930

20 UNDERTAKER: M. W. Dyer Inc — ADDRESS: 311 Cathedral

Spec.—1-30—M. & T.—250 Bks

E 61205

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61205

CERTIFICATE OF DEATH.

× 185

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD) 30

2-FULL NAME Annie S. Cook

(a) RESIDENCE NO. Cockeysville Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 24, 1883

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cockeysville Md

PARENTS

10 NAME OF FATHER Frederick Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Benj. B Cook. (Address) Cockeysville R.F.D. Box 4

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 30 ..... 19 30, to Oct 9 ..... 19 30, that I last saw her alive on Oct 9 ..... 19 30, and that death occurred, on the date stated above, at 9:40 A m.

The CAUSE OF DEATH* was as follows:

Fractures of left clavicle, left wrist, and left 7th & 8th ribs

Accidental Death. Fell down stairs (duration) ..... yrs. ..... mos 19 ds.

CONTRIBUTORY (Secondary) Pneumonia, hypostatic (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Cockeysville Md

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings and autopsy

(Signed) C. E. Anderson M. D.

..... 19 ..... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sweet Air Cemetery Co.

DATE OF BURIAL 10-11-1930

20 UNDERTAKER Joshua Barnes Sons

ADDRESS Towson

1-a —M. & T.—100 B—50L

E 61206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001 167-E 61206

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Immanuel Baptist Church ST. E-16 WARD)

2-FULL NAME Charles Edward Tansill

(a) RESIDENCE NO 1424 N. Luzerne Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20-9 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of Anne W. (Jones) Tansill
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Telephone Supervisor 03
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) W.Va.

PARENTS

10 NAME OF FATHER Wm. Tansill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Anne W. Tansill
(Address) 1424 N. Luzerne Ave

15 C. THOMPSON JONES, M. D.
Registrar

1930 192

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Asphixiation
Suicide. (turned on gas range in social room of church)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..... Coroner, M. D.

Oct 9/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 10/11/19 30

20 UNDERTAKER E. J. Fanning & Son - 1938 E. Lafayette Ave

ADDRESS

1-30—M. & T.—100 B—50L

E 61207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 61207

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3032 Clifton Park Terrace ST., 8-45 WARD

2-FULL NAME Timothy J. Cronin

(a) RESIDENCE NO 3032 Clifton Park Terrace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50? yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Cronin

6 DATE OF BIRTH (month, day, and year) Nov 8/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	11	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman 673
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) Balto. Co., Md.

PARENTS

10 NAME OF FATHER John Cronin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine ---- Oct 8/30

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Gordon Cronin

(Address) 3032 Clifton Park Terrace

15 [illegible] - 1930 C. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Chr Myocarditis

.....
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W. C. Culler, M. D.
Coroner

Oct 8/30 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 10/11 1930

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1402 Light St.

1-30—M. & T.—100 B—50L

Henry A. Barron. ✓

E 61208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61208

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 706 N. Fulton St. 16-22 (WARD)

2-FULL NAME Henry A. Barron

(a) RESIDENCE NO 706 N. Fulton St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary B. Barron

6 DATE OF BIRTH (month, day, and year): June 1876

7 AGE: Years 54 | Months 9 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 020
(c) Name of employer: Woodstock Va.

9 BIRTHPLACE (city or town) (State or country): Woodstock Va.

PARENTS

10 NAME OF FATHER: Wallace Barron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va. or D.C.

12 MAIDEN NAME OF MOTHER: Elizabeth Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mary B. Barron

(Address): 706 N. Fulton

15 Filed ..... 19 ..... Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris 2 Seconds

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) ..... M. D. Coroner

19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

20 UNDERTAKER: Geo. H. Little

DATE OF BURIAL: OCT 10 1930

ADDRESS 2900 EDMONDSON AVE

C. HAMPSON JONES, M. D.

9 - 1930

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61209

126 E 61209

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 4214 Greenway ST.; 27½ WARD

2-FULL NAME Laura Virginia Applegarth

(a) RESIDENCE. NO. 4214 Greenway ST., 25th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND or) WIFE of: Charles L. Applegarth

6 DATE OF BIRTH (month, day, and year): March 9, 1854

7 AGE: Years 76 Months 7 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk, Virginia U.S.A.

PARENTS

10 NAME OF FATHER: Thomas Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cambridge Md. U.S.A.

12 MAIDEN NAME OF MOTHER: Eliza Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dorchester Co Md. U.S.A.

14 Informant (Address): Frank S. Charannes 4214 Greenway

15 Filed 10/9 1930. H. HAMPSON JONES, M. D. Registrar

Reg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30 1930, to Oct. 9th 1930, that I last saw her alive on Oct. 9th 1930, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Colitis

CONTRIBUTORY (Secondary) (duration) 2 yrs. — mos. — ds. General Peritonitis

(duration) 0 yrs. 0 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

10/9/1930 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glen Mount Md. DATE OF BURIAL: Oct 11th 1930

UNDERTAKER: Joseph L. Cook ADDRESS: 1003 N. Calvert St

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61210

CERTIFICATE OF DEATH

88 E 61210

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2520 W. Baltimore ST. 20-69 WARD)

2—FULL NAME J. George Schlesinger

(a) RESIDENCE NO. 2520 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwardena Schlesinger

6 DATE OF BIRTH (month, day, and year) April 22, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railway Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Antan Schlesinger

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Katherine Vogler

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Miss Mabel C. Schlesinger

(Address) 2520 W. Baltimore St.

Filed 10-9-1930 19 C. HAMPSON JONES, M. D.

Per ach (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 25- 1930, to Oct 9- 1930, that I last saw him alive on Oct 8- 1930 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis (Rheumatic)

Chr - Bronchitis - Arteriosclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norbert C. Mitsch M. D.

(Address) 2151 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct. 11 1930

20 UNDERTAKER Harold B Cook

ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61211

CERTIFICATE OF DEATH

90 E 61211

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 W. North Ave. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Salvatore Zito

(a) RESIDENCE NO. 629 W. North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Rosario Zito

7 DATE OF BIRTH (month, day, and year) November 2, 1869

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Vincent Zito

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Vincent Zito

(Address) 629 W. North Ave.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 10- 1930, to Oct. 8- 1930, that I last saw h im alive on Oct 8. 1930 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Disease, Mitral + Aortic insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Chronic Gastritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) H. W. Sibitz, M. D.

10/9 1930 (Address) 1117 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent Cemetery

20 UNDERTAKER Joseph B Cook

DATE OF BURIAL Oct. 11 1930

ADDRESS 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

E 61212 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61212

49

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No.) North Broadway St. 16-67 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Krause, Anna (Anne H. Krause)

(a) RESIDENCE NO. 2913 Brighton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 11, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer L. A. Benson Co.

9 BIRTHPLACE (city or town) Manchester
(State or country) Maryland

PARENTS

10 NAME OF FATHER Gustavas A. Krause

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret A. Stoever

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Patient Mr. C. F. Cobourn
(Address) 2913 Brighton St.

15 Filed 1930 C. Hampson Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from September 30, 1930, to October 8, 1930, that I last saw her alive on October 8, 1930, and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

? Pulmonary tuberculosis

?? Carcinoma of lung (metastatic)

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac failure 24 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? NO

What test confirmed diagnosis? There is a guinea pig inoculation Oct 7 11.

(Signed) Oscar E Halbert M. D.

10/8/30 (Address) 409 Cornwall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md.

DATE OF BURIAL Oct. 10 1930

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61213

90 E 61213

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Christian ST. 70-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A. McCubbin

(a) RESIDENCE NO. 2223 Christian ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary I. McCubbin

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore & Ohio R.R.

9 BIRTHPLACE (city or town) (State or country) Mt. Airy Maryland

10 NAME OF FATHER James McCubbin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER - Spurrier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Mary I. McCubbin

(Address) 2223 Christian St.

15 Filed 9 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Oct 7, 1930,

that I last saw him alive on Oct 7, 1930

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman M. D.

Oct 8, 1930 (Address) 2687 Wilkens St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Oct. 10 1930

UNDERTAKER Joseph Cook

ADDRESS 1305 West Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

Dr Dietrich. Med Tech 13 Dg

E 61214 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61214

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home of Incurables REGISTERED NO. 74

CITY OF BALTIMORE: (No. 12-50 St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma B Dexter

(a) RESIDENCE NO. 2727 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John A Dexter

6 DATE OF BIRTH (month, day, and year): Sept 4 1873

7 AGE: Years 57 | Months 1 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): White Stone Long Island N.Y.

PARENTS

10 NAME OF FATHER: William Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Caroline Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: John A Dexter (Address) 2727 St Paul St

15 Filed 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1 1930 to Aug 8 1930, that I last saw him alive on Aug 7 1930, and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Cerebral Apoplexy

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. Hurtt M. D.

, 19 (Address) Dexter Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 10/10 1930

20 UNDERTAKER: William Cook — ADDRESS: 1217 E Pratt St

Spec.—1-30—M. & T.—250 Bks

E 61215

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61215

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. —— ST., 710 WARD)

2-FULL NAME John Joyave.

(a) RESIDENCE NO. 534 S. Eduard Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) July 31, 1856.

7 AGE	Years	Months 2	Days	If LESS than 1 day, ...hrs. or ....min.
	74	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, professaion or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alex Joyave.

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Annie Fahey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Records ?

(Address) BALTIMORE CITY HOSPITALS

Filed 10-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1916, to Oct 9, 1930, that I last saw him alive on Oct. 9, 1930, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tonsil

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinically and biopsy.

(Signed) Paul Padgett. M. D.

10-9-1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 10/11 1930

20 UNDERTAKER William Cook

ADDRESS 1217 E. Fond St

Spec.—1-30—M. & T.—250 Bks.

E 61216

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61216

CERTIFICATE OF DEATH.

90

REGISTERED NO. 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5417 Reisterstown Rd. ST. 27 WARD

2-FULL NAME John H Robinson

(a) RESIDENCE NO. 5417 Reisterstown Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of The late Mary A.

6 DATE OF BIRTH (month, day, and year) Aug 12th 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75.	2.	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co.

PARENTS

10 NAME OF FATHER James Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Mary Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Margaret L Wagner

(Address) 5417 Reisterstown Rd

15 Filed OCT 10 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to Oct 9, 1930.

That I last saw him alive on Oct 8, 1930, and that death occurred, on the date stated above, at About 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

from history (duration) about 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? --

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S. Riblett, M. D.

, 19 (Address) 2220 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Oct 11 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

Dr Kyper
3321 Frederick Rd

E 61217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 61217

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3312 Old Frederick Rd. WARD 40)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Tellis

(a) RESIDENCE No. 3312 Old Frederick ST. Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 27, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Walter A. Tellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr Walter A. Tellis
(Address) 3312 Old Frederick Rd

Filed OCT 8 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Oct 8, 1930

that I last saw him alive on Oct 8, 1930

and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) Fred T. Kyper, M. D.

, 19 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Oct 10 1930

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Bke.

V

24134 med 24218

HEALTH DEPARTMENT—CITY OF BALTIMORE E 61218

CERTIFICATE OF DEATH. × 54

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loyal Spangenberg

(a) RESIDENCE NO. Dillsburg Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

6 If married, widowed, or divorced HUSBAND of or) WIFE of W. K. Spangenberg

6 DATE OF BIRTH (month, day, and year) Dec 24 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Isaac Stamy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lucy H. Barch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-9-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1930, to Oct-9, 1930, that I last saw her alive on Oct-9, 1930, and that death occurred, on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harrisburg Pa, & vicinity

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Caroline C. Bedell M. D.

10/9, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dillsburg Pa — DATE OF BURIAL 10/11 1930

20 UNDERTAKER Wm Cook — ADDRESS 124 S Paca

Spec.—2-29-28—L. F. S.—500 Bks.

DN Link

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61219

CERTIFICATE OF DEATH

166 E 61219

REGISTERED NO.

1—PLACE OF DEATH Md. Gen. Hosp. Fal ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2—FULL NAME Mrs Emma Swift

(a) RESIDENCE NO. 932 N. Chas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

6 If married, widowed, or divorced (Husband) of John F. Swift.

7 DATE OF BIRTH (month, day, and year) Aug 9, 1902

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER H. Carl Vetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital records

(Address)

Filed 9-1930 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-30

17 I HEREBY CERTIFY, That I attended deceased from 10-6, 1930, to 10-9, 1930, that I last saw her alive on 10-9, 1930 and that death occurred, on the date stated above, at 7:40 A m.

The CAUSE OF DEATH* was as follows:

Ex-chlorate poisoning over

(duration) yrs. mos. 5 1/2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Corrected to Chronic Nephritis)

Where did disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert K. Abrams, M. D.

. 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

UNDERTAKER Fulton Cook

DATE OF BURIAL 10/11 1930

ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Duker 928 E North Ave
Univ 0368

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61220

CERTIFICATE OF DEATH

90 E 61220

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 503 Radnor Ave ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth M Bader

(a) RESIDENCE NO. 503 Radnor Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Henry

DATE OF BIRTH (month, day, and year) July 14, 1858

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	2	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer At Home

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Christopher Middour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ruby Mac Donnell

(Address) 503 E Radnor Ave

15 Filed 10-9-1930 C. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 1930 to Oct 9 1930, that I last saw HER alive on Oct 9 1930 and that death occurred, on the date stated above, at 3 45 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) X yrs. X mos. 5 ds.

CONTRIBUTORY (Secondary) Hypertension & Chronic Myocarditis & Cardiitis (duration) 10 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical alone

(Signed) Jacob Duker, M. D.

July 1930 (Address) 928 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL 10/11 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

E 61221 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61221

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2442 ... St., 7-12 Ward)

2-FULL NAME ...

(a) RESIDENCE NO. 2442 ... St., ... Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 27 1

7 AGE — Years: 1 — Months: — Days: 12 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Annie Bussard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mrs. Turner

(Address) 2442 Mun St

15 Filed 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Oct 9, 1930, that I last saw h... alive on Oct 9 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Flea Cal[illegible]

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) ... M. D.

Oct 10, 1930 (Address) 2442 Mun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Oct 10 1930

20 UNDERTAKER: John C. Miller

ADDRESS: 2435 E Monument St

Spec.—1-30—M. & T.—250 Bks

E 61222 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 61222

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 N. Carey - St. 14-27 Ward)

2-FULL NAME Jamie Elizabeth Boardley -

(a) RESIDENCE NO. 233 N. Carey St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. + mos. + ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of John H. Boardley

6 DATE OF BIRTH (month, day, and year) — 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	+	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George W. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant John H. Boardley (Address) 233 N Carey

15 Filed OCT 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Oct 9, 1930, that I last saw h[illegible] alive on Oct 8 1930, and that death occurred, on the date stated above, at 2:15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy -

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) 6th Endocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Wm Strandberg, M. D.

10/9, 1930 (Address) 122 W 4th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon DATE OF BURIAL Oct 12 1930

UNDERTAKER Virginia A Brooks ADDRESS 1463 N Case

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61223 165 E 61223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Hopkins Apts St. 12-50 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anne Blakistone Hinke

(a) RESIDENCE NO. Hopkins Apts St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? 57 yrs. 9 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: George M. Hinke

6 DATE OF BIRTH (month, day, and year): December 13 1872

7 AGE — Years: 57 Months: 9 Days: 25 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

10 NAME OF FATHER: Walter Blakistone

11 BIRTHPLACE OF FATHER (city or town): St Marys Co

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sallie Sinclair

13 BIRTHPLACE OF MOTHER (city or town): Norfolk

(State or country): Virginia

PARENTS

14 Informant: Mr Geo M Hinke (Husband)

(Address) Hopkins Apts City

Registered: 10/1930

C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Streptococcus Toxemia

Sepsis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H Mowry M. D.

(Coroner)

10/9, 1930 (Address) 2622 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Hopkins Apts

Former or usual residence Hopkins Apts

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial 10/10 1930

20 UNDERTAKER: Stewart Mortuary ADDRESS Balto

T 10 1930

Spec.—1-30—M. & T.—250 Bks.

E 61224 E 61224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1133. Harlem St. 16-26 (WARD)

2-FULL NAME Eliza Monroe

(a) RESIDENCE NO. 1133 Harlem St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (~~write~~ the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Delaware Monroe

6 DATE OF BIRTH (month, day, and year): Autumn

7 AGE: Years 57; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): a a Co Md

PARENTS

10 NAME OF FATHER: Richard Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Roberta Bell
(Address) 1133. Harlem St.

15 10 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 - 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Oct 8, 1930, that I last saw h.. alive on Oct 8, 1930, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(duration) 2 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

*Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Cathey, M. D.

10-9. 1930 (Address) 1133 Harlem St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M-Gan Com

DATE OF BURIAL: 10-11 1930

20 UNDERTAKER: Sam. M. Chase & Son

ADDRESS: 1405 Mosher

Spec.—8-16-29—L. F. S.—100 Bks.

RYJACEK

E 61225 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61225

74-001

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 831 N. Washington ST., 7-13 WARD)

2—FULL NAME Joseph Ryjacek

(a) RESIDENCE NO. 831 N Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Ryjacek

7 DATE OF BIRTH (month, day, and year) not known

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

10 NAME OF FATHER Albert Ryjacek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Emma Hala

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Emma Ryjacek

(Address) 831 N Washington St

15 OCT 10 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Oct 8, 1930, that I last saw h[illegible] alive on Oct 8 1930, and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Arterial Hemorrhage

(duration) 24 hrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F Ryan, M. D.

Oct 9 1930 (Address) 502 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Oct 11 1930

20 UNDERTAKER Frank Carroll & Son — ADDRESS 906 Hollins

Spec.—1-30—M. & T.—250 Blks

E 61226 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61226

CERTIFICATE OF DEATH. 21

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. # 411 N. Carey ST., 18-26 WARD)

2-FULL NAME Margaret Nellie Cauffield

(a) RESIDENCE NO. # 411 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Harry H. Cauffield

6 DATE OF BIRTH (month, day, and year) Dec. 27, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Richard S. Prather

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Nellie Coale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mr Harry H. Cauffield

(Address) # 411 N. Carey St

15 Filed 1930 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1930.

17 I HEREBY CERTIFY, That I attended deceased from 7/4, 1930, to 10/9/1930,

that I last saw h alive on 10/8/30, 19....,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cer. Athero sclerosis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By signs, history of illness & Post Mortem

(Signed) Bernard J. Terry, M. D.

10/10/1930 (Address) 9 o W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 10/11/1930

20 UNDERTAKER John J. Lawran & Son

ADDRESS 901 Hollins St.

Spec.—1-30—M. & T.—250 Bks

E 61227 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61227

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L. Panebaker

(a) RESIDENCE NO. Westminster Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Panebaker

6 DATE OF BIRTH (month, day, and year) Nov. 16. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3.	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Martin E. Bollinger

11 BIRTHPLACE OF FATHER (City or town) (State or country) Adams Co. Pa

12 MAIDEN NAME OF MOTHER Eliza Jane Young

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Maryland

14 Informant George Panebaker. (Address) Westminster Md

15 Filed 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1930, to Oct. 9, 1930, that I last saw h[illegible] alive on Oct. 9, 1930, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Incarcerated Ventral Hernia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Oct. 7, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Yeager M. D.

10/9, 1930 (Address) Mem. University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md

DATE OF BURIAL Oct 12 1930

20 UNDERTAKER H Bankard & Son

ADDRESS Westminster Md

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

E 61228

CERTIFICATE OF DEATH

E 61228

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 E. Fayette ST. 6-10 WARD)

2-FULL NAME Sophie Cohen

(a) RESIDENCE No. 2317 E. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gerson Cohen

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Abraham --

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Edith ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant ..... (Address) .....

15 Filed 10 1930 19 WILLIAM JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Coronary Thrombosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... Coroner, M. D.

19 ( ) (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL 10-10 19 30

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St

Spec.—1-12-23—M&T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61229 87 E 61229

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 190 A Edmondson Ave St. (WARD) 20-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina E. Yakel

(a) RESIDENCE NO. 1901 Edmondson St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J Yakel

6 DATE OF BIRTH (month, day, and year) June 5 1850

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
80	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Caspar Hunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherina Dubes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm J Yakel

(Address) 1901 Edmondson Ave

15 Filed Oct 10 1930 . 19 . C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept-19 . 1930 . to Oct. 8 . 1930 .

that I last saw h alive on Oct 7 . 1930 ,

and that death occurred, on the date stated above, at 420 A m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis 8

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. O'Neill M. D.

10/9. 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	10/11 1930
UNDERTAKER Boyd & Fahey	ADDRESS Fayette

Spec- 12-23-21-E.B.R.S.—400 Blks.

E 61230 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61230

CERTIFICATE OF DEATH.

113

Registered No. [redacted]

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1709 N Saratoga St., (Ward) 14-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara M Hill

(a) Residence No. 1709 N Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX 7

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 6-30

7-AGE Yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS

10-NAME OF FATHER. William Hill

11-BIRTHPLACE OF FATHER (city or town) (State or Country). NC

12-MAIDEN NAME OF MOTHER. Ida Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14- (Informant) Mrs Todd

(Address) 1709 N Saratoga

15- Filed [illegible], 19[illegible] C. HAMPSON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-9-1930

17- I HEREBY CERTIFY, That I attended deceased from Sept 25, 1930 to Oct 9, 1930, that I last saw h. alive on Oct 9, 1930, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows: Gastro Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL. 10-10, 1930

20-UNDERTAKER [signature]

ADDRESS 916 Eager

Spec.—1-30—M. & T.—250 Bks.

E 61231 E 61231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH Baltimore City Hospitals (ST. 15 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. .....

2-FULL NAME Mary Rusk

(a) RESIDENCE NO. 1334 N Carey ST., ... WARD ..... (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... da. How long in U. S., if of foreign birth? ... yrs. ... mos. ... da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 15, 1894

7 AGE: Years 36; Months —; Days —; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Ball ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Rusk (Address) [illegible]

15 Filed ... 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7-30

17 I HEREBY CERTIFY, That I attended deceased from 10-6-, 1930, to 10-7-, 1930, that I last saw her alive on 10-7-, 1930, and that death occurred, on the date stated above, at 3 55 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of body of uterus

with local metastasis

(duration) ... mos. ... da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 1 da.

18 Where was disease contracted if not at place of death? In person.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Fred M. Buckwalter, M. D.

, 19 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mary Point Lancaster Co Va

DATE OF BURIAL Oct 10 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Freedman St

Spec.—1-30—M. & T.—250 Bks

E 61232

E 61232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T. B.)

CITY OF BALTIMORE: (NO. 14-30 ST. WARD)

2-FULL NAME (Hannie) Carroll Harmon

(a) RESIDENCE NO. 2022 N. Brunt st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Maria Harmon

6 DATE OF BIRTH (month, day, and year) March 11, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Longshoreman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Arthur Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Caudis Reade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed OCT 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930 to Oct. 9, 1930, that I last saw him alive on Oct. 9, 1930, and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lung, extending to anterior chest wall.

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Seman, M. D.

10-9, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery

DATE OF BURIAL Oct. 11 1930

UNDERTAKER Thomas E. Nelson

ADDRESS 1303 Pressman St

Spec.—1-30—M. & T.—250 Bks

E 61233

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61233

129

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 N, Mount st. ST. 14-27 WARD)

2-FULL NAME George Edward Browner

(a) RESIDENCE NO. 24 N. Mount st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Abt. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adeline Browner

6 DATE OF BIRTH (month, day, and year) April 21st. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chas. Co., Md.

PARENTS

10 NAME OF FATHER Soney Browner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chas. Co., Md.

12 MAIDEN NAME OF MOTHER Caroline Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caroline Co. Md.

14 Informant Wm. Browner

(Address) 1807 Vine st.

FILED OCT 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8-'30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6th. 1930 to Oct. 8th. 1930, that I last saw h. alive on Oct. 8th. 1930 and that death occurred, on the date stated above, at 11:45a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Ch. Int. Nephritis About 2 yrs. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

UNDERTAKER Wa. Jones

DATE OF BURIAL Oct 11th 19 30

ADDRESS 111 S. Gilmor

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

61234 E 61234

REGISTERED NO. 71-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Butler Ave ST. Hosp. WARD 24

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. Hendricks

(a) RESIDENCE NO. 743 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Hendricks

6 DATE OF BIRTH (month, day, and year) Nov 27-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	10	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hotel Lauderac

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Lewis Hendricks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mecklenburg Co Va

12 MAIDEN NAME OF MOTHER Alice Easterwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Gertrude Hendricks

(Address) 743 Dolphin St

15 Oct 8 1930 192

HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to (Death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumo Coccic Meningitis

(duration) yrs. mos 4 ds.

*CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriology

(Signed) H. Haiselip, M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10/11 1930

ADDRESS

20 UNDERTAKER Samuel J. Hemler 578 N Bond

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61235 3/ E 61235

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 13-54 WARD)

CITY OF BALTIMORE: (NO. ST.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Baysmore

(a) RESIDENCE NO. 2325 McCulloh st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Chas. Baysmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Records

(Address)

15 Filed OCT 10 1930 M. JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to Oct. 8, 1930, that I last saw h. im alive on Oct. 8, 1930, and that death occurred, on the date stated above, at 12.15 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) David Lesser M. D.

10-8 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Oct 10 1930

20 UNDERTAKER Samuel Hemsley ADDRESS 578 N Bridle

Cor.—10-10-29—A Co.—100 Bks.

E 61236

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61236

90

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

(City of Baltimore: (No. 409 N. Wolfe St St.) 6-9 Ward)

2-FULL NAME Annie L. Dyer

(a) RESIDENCE NO. 409 N Wolfe St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas A. Dyer

6 DATE OF BIRTH (month, day, and year) Nov 13/1863

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	66	11	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Lister

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Germany

14 Informant Chas A. Dyer
(Address) 409 N. Wolfe St

15 Filed ... G. HAMPSON JONES, M. D.
Registrar

101930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Probably Coronary Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Jos. W. Cairns, M. D.

Oct. 19 30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon PK	Oct 13 19 30
20 UNDERTAKER Phelps Henry	ADDRESS Edmondson Ave

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61237 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61237

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3720 E. Pratt ST. 16-37 WARD

2-FULL NAME Annie Kane

(a) RESIDENCE NO. 3720 E Pratt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Kane

6 DATE OF BIRTH (month, day, and year) Jan 16/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Frederick Klinegard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ruda Kane
(Address) 3720 E. Pratt St.

15 Dec. ..... 19..... C. HAMPSON JONES, M. D.
Registrar

101930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9/30

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to 10/9, 1930, that I last saw h[er] alive on 10/9, 1930, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of the Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Angelo J. Scudder, M. D.

10/9, 1930 (Address) 3535 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Oct 12, 1930

UNDERTAKER Philip Stewig

ADDRESS 2016 Eutaw St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61238

CERTIFICATE OF DEATH

109-002

E 61238

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1638 E. Baltimore St. St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward W. Conrad

(a) RESIDENCE NO. ~~1638 E. Baltimore St.~~ St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/13/30

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
			27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Edward Conrad.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Cecelia Lang

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant

(Address)

15 C. HAMPSON JONES, M. D. Registrar

101930 per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 October 9, 1930

I HEREBY CERTIFY, That I attended deceased from 10/9/30, 19..., to 10/9/30, 19...,

that I last saw him alive on 10/9/30, 19...,

and that death occurred, on the date stated above, at 8.30P. m.

The CAUSE OF DEATH* was as follows:

Septic sore throat

(duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. Sullivan, M. D.

10/9/30 (Address) 2214 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Md. University Med. School

Date of Burial 19

20 UNDERTAKER

ADDRESS

very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

61239

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 E 61239

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 20-10 (WARD)

2-FULL NAME Louis Marley

(a) RESIDENCE NO. 316 Stafford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Marley

6 DATE OF BIRTH (month, day, and year) Aug 28 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto and.

PARENTS

10 NAME OF FATHER John Marley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Bertha Manley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Bertha Manley (Address) 316 Stafford St

15 Filed OCT 10 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Oct 8th, 1930, that I last saw h[illegible] alive on Oct 8th, 1930, and that death occurred, on the date stated above, at 5:15 p m.

The CAUSE OF DEATH* was as follows:

Intussusception & Marasmus.

(duration) yrs. One mos ds.

CONTRIBUTORY (Secondary) Bullous Impetigo

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of —

Was there an autopsy?

What test confirmed diagnosis? Gross & Capt Clinical findings.

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hosp Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Oct 10 1930

20 UNDERTAKER H. B. Wyphut

ADDRESS 850 W Baltimore

Spec.—2-29-28—I. F. S.—500 Bks.

E 61240

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61240

CERTIFICATE OF DEATH

REGISTERED NO. 43

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 381 EVESHAM St. AVE WARD 43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME GRACE GERTRUDE GILL,

(a) RESIDENCE NO. 381 EVESHAM AVE. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: FEM.

4 COLOR OR RACE: WHITE

5 Single, Married, Widowed, or Divorced, (write the word): MARRIED

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: FRANK C. GILL

6 DATE OF BIRTH (month, day, and year): FEB. 20, 1886

7 AGE — Years: 44 — Months: 7 — Days: 17 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Chesapeake City Maryland

PARENTS

10 NAME OF FATHER: William Triston

11 BIRTHPLACE OF FATHER (City or town) (State or country): Chesapeake City Maryland

12 MAIDEN NAME OF MOTHER: Rachel Carley

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Chesapeake City Maryland

14 Informant: Mrs. William Woods

(Address) Edmondson Ave.

15 DATE RECEIVED: 10 1 1930 — C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): OCT. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from OCT. 6, 1930, to OCT 7, 1930, that I last saw her alive on Oct. 7, 1930 and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

CARCINOMA OF RIGHT SUPERIOR MAXILLA WITH METASTASES

(duration) 3 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of March 1927

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John R. Heuisler M. D.

Oct 8, 1930 (Address) 3524 Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Crem — DATE OF BURIAL: 10-10 1930

20 UNDERTAKER: Mrs Chas G Rohde — ADDRESS: 2327 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

Baker.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61241 — 161-001 ✓ — E 61241

CERTIFICATE OF DEATH

REGISTERED NO. 13459

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Angela Frances Lakeh

(a) RESIDENCE NO. 2104 Mt Royal Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: —

7 DATE OF BIRTH (month, day, and year): Oct 8, 1930

8 AGE — Years | Months | Days: 1 X | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Baltimore

11 NAME OF FATHER: Edwin J. Lakeh

12 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

13 MAIDEN NAME OF MOTHER: Edna Hunt

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

15 Informant: Hospital Records.

(Address)

Filed 10 1930 19 — C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1930, to Oct 9, 1930, that I last saw her alive on Oct 9, 1930 and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:

Prematurity.
(Fetus of 7 months)
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Premature Separation of Placenta
(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas L Foltz Jr. M. D.

10/9, 1930 (Address) Bon Secours Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Oct. 10 1930

20 UNDERTAKER: Joseph Cook

ADDRESS: 1003 West Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61242 179 E 61242

REGISTERED NO. 42-33

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital, Ward)

2-FULL NAME Ella Picklowsky or Pozecanchuk.

(a) RESIDENCE NO. 716 Light St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ---- mos. ---- ds. How lung in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married.

5a If married, XXXXXXXXXXXX (or) WIFE of Fred Pozecanchuk.

6 DATE OF BIRTH (month, day, and year) 1885 Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lithanian.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) Do not know.
(State or country)

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) Do not know.
(State or country)

14 Informant William Picklowsky (son)
(Address) 716 Light St.

15 Filed OCT 1930 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about the body and limbs.
from a gas stove.
Accidental Death.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 716 Light St. October 5, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto W. Steinhardt, M. D.

10/9 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct. 11 1930
20 UNDERTAKER	ADDRESS
Chas. B. Kuchawska	637 S. Paca St.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61243

CERTIFICATE OF DEATH.

129 E 61243

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 26-37 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald McHoney (DANIEL MAHANEY)

(a) RESIDENCE NO. 3713 E. Lombard ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	Unknown	Unknown	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Timothy Mahoney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Corcoran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Record Mercy Hospital

15 Filed OCT 10 1930 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1930, to Oct 7, 1930,

that I last saw him alive on Oct 9, 1930,

and that death occurred, on the date stated above, at 11 25 Am.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hydronephrosis & Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) J. H. Goodman, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Oct. 11th 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61244 ✓ E 61244

CERTIFICATE OF DEATH

148

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 318 S. Collington Ave St. 1-3 Ward)

2-FULL NAME Antonia Dobrochowski

(a) RESIDENCE NO. 318 S Collington Ave St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ignatius Dobrochowski

6 DATE OF BIRTH (month, day, and year) May 1 1890

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs or ..... min.
	40	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home 037
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Poland

PARENTS

10 NAME OF FATHER Jacob Mrozek

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Caroline Drynala

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Rose Borski
(Address) 235 S Madeira St

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

CT 101930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute .....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Puerperal Convulsions

..... (duration) ..... yrs. few mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL Oct. 11 1930

20 UNDERTAKER Lilly & Julian Inc

ADDRESS 4035 S. Wolfe St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 61245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 61245

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 21-31 Ward)

2-FULL NAME Lee Jordon.(C)

(a) RESIDENCE NO. 424 W.Hamburg St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ---------- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed or divorced, HUSBAND of XXXXXXXX Alverta Jordon.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	36	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.W.Md.R.R.Co.
(b) General nature of industry, business, or establishment in which employed (or employer) Grain Elevator. ono
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Robert Jordon.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Eliza Goodman.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Charles Jordon.(C) brother.
(Address) 753 Aceland St.

T 101930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Extensive burns about the face and body due to an explosion in W. Md. R. R. Grain Elevator. Occidental Death.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? W. Md. R. R. Grain Elevat.
Date of August 20, 1930

Did an operation precede death? No.
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt M. D.

10/9. 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct — DATE OF BURIAL Oct 11 1930

20 UNDERTAKER A. L. Brown's Son — ADDRESS 1017 W. Mad

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 61246 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61246

38

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bon Secours Hospital
CITY OF BALTIMORE: (NO. Balto Md. ST. 10-14 WARD)

2-FULL NAME Jessie Johnson

(a) RESIDENCE NO. 872 McKean St st., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Black
5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE — Years: 50 — Months: — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Ben Johnson
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Records Bon Secours Hospital

15 BURIAL, CREMATION OR REMOVAL ..... 19 .....
Undertaker's Address .....

101930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8-30

17 I HEREBY CERTIFY, That I attended deceased from 9-26-, 1930, to 10-8-, 1930, that I last saw h[illegible] alive on 10-7-, 1930, and that death occurred, on the date stated above, at 4:10 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Luetic Infection
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical Serological.

(Signed) [illegible] M. D.
10/9, 1930 Address Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littleton N. Carolina
DATE OF BURIAL 10-10 1930
ADDRESS

UNDERTAKER Byrom & Wright 1218 McElderry St

Spec.—1-30—M. & T.—250 Bks

E 61247

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61247

CERTIFICATE OF DEATH.

75-001

REGISTERED NO. 26-42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4213 Belmar Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma S. Whitlock

(a) RESIDENCE NO. 4213 Belmar Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John W. Whitlock

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Elmira Frazier

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Florence Heffner

(Address) 4213 Belmar Ave.

15 Date 10 1930, 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Oct 9, 1930

that I last saw her alive on Oct 9, 1930

and that death occurred, on the date stated above, at 9:12 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia. right

(duration) 2 yrs. 2 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jane C. Clark, M. D.

(Address) 1 or Take Apt. Chesterfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Oct. 11 1930

20 UNDERTAKER Frederick Lassahn Son

ADDRESS 7401 Belair Rd.

I-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61248

182 E 61248

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Frost & Wolfe St. 2-4 WARD)

2-FULL NAME Unknown

(a) RESIDENCE NO Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55?				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 087
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant

(Address)

OCT 1930 C. HAMPSON JONES, M. D.
Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Accidental Drowning

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. C. Hartman, Coroner

Oct. 1, 1930 (Address) 443 N. Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
PUBLIC CEMETERY.

20 UNDERTAKER
Commissioner Health

DATE OF BURIAL
..... 19

ADDRESS
OCT 10 1930

Spec.—I-30—M. & T.—250 Bks

E 61249 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61249

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 12-50 ST., WARD)

2-FULL NAME Frank Mimms

(a) RESIDENCE NO. 2101 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie

6 DATE OF BIRTH (month, day, and year) July 15, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer gdo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 10 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5-30

17 I HEREBY CERTIFY, That I attended deceased from 5-15-30, 19..., to 10-5-30, 19...,

that I last saw him alive on 10-5-30, 19...,

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

Morethan (duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Irene Padgett, M. D.

10-9-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAN

DATE OF BURIAL OCT 1 1930

ADDRESS

20 UNDERTAKER

C. HAMPSON JONES, M. D.
Commissioner of Health.

Spec.—1-30—M. & T.—250 Blks.

241165
Ped.
E 61250

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61250

CERTIFICATE OF DEATH.

REGISTERED NO. 112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Sumler

(a) RESIDENCE NO. 731 No. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Child

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Sumler

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Eddie Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed OCT 10 1930, 19 For NRA

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to Oct-7, 1930, that I last saw him alive on Oct-7, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Entero colitis + Diarrhea.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Rhinopharyngitis + Otitis media

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) T. C. Goodwin, M. D.

10/8, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER (Use Commissioner Health.)

ADDRESS OCT 10 1930

Rep. Wm. H. Woodall

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~E 61251~~ 4½E 61251

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 E. 22nd St. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Concannon

(Residence in Baltimore: No. 313 E. 22nd St. 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, Dec. (Month) ..... (Day) ....., 1855 (Year)

7-AGE, 74 yrs. 9 mos. ✓ ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At H. 10
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Galway Co. Ireland.

PARENTS.

10-NAME OF FATHER, Martin Concannon

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Donahue

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Lyston - Sister

(Address) 313 E. 22nd St.

15-

Filed ....., 191.....

C. HAMPSON JONES, M. D. Registrar.

TD 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 8 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1930, to Oct 8 1930, that I saw her alive on Oct 7 1930, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ...yrs. 8 mos. ...ds.

CONTRIBUTORY (Secondary) ..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Wm. Pilsbury M. D.

Oct 8, 1930 (Address) 415 Cedar Croft Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Catholic Cemetery

DATE OF BURIAL, Oct. 11..., 1930

20-UNDERTAKER Mary M. Neufeld

ADDRESS 501 E. 32nd St

Spec.—1-30—M. & T.—250 Bks

E 61252

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61252

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (No.) 76-1 (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: John A. Koos

(a) RESIDENCE NO. 122 S. Highland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise Koos

6 DATE OF BIRTH (month, day, and year): July 8, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman (Pensioned)

(b) General nature of industry, business, or establishment in which employed (or employer): O.K.

(c) Name of employer: Fire Dept.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Records of Balto. City Hosp.

15 C. HAMPSON JONES, M. D. Registrar

01930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-10-30

17 I HEREBY CERTIFY, That I attended deceased from 7-31-30, 19.., to 10-10-30, 19.., that I last saw him alive on 10-10-30, 19.., and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus (3 years)

Diabetic Gangrene, rt. foot (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? 1 & 2 Hams. 3 Hospital

Did an operation precede death? yes Date of 8-20-30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinic & Lab. Laboratory

(Signed) Paul Padget, M. D.

10-10-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Oct 13 1930

20 UNDERTAKER: John A. Ritz ADDRESS: 404 S. High

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61253 E 61253

CERTIFICATE OF DEATH.

REGISTERED NO. 25-73

1-PLACE OF DEATH Union Memorial Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calvert & 33rd ST. WARD)

2-FULL NAME Julius W. Nilson

(a) RESIDENCE NO. 410 Potapsco Ave. ST., Brooklyn Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white.	Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of .

6 DATE OF BIRTH (month, day, and year) June 7-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Yacht Builder.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sweden
(State or country)

PARENTS

10 NAME OF FATHER John Nilson.

11 BIRTHPLACE OF FATHER (city or town) Sweden
(State or country)

12 MAIDEN NAME OF MOTHER Julia Morrison

13 BIRTHPLACE OF MOTHER (city or town) Sweden.
(State or country)

14 Informant Mrs William L. Hawkins.
(Address) 410 Potapsco Ave.

15 Filed ..... 19 ..... Registrar

0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1930, to October 10. 1930.
that I last saw him alive on October 10, 1930.
and that death occurred, on the date stated above, at 3.05 Am.

The CAUSE OF DEATH* was as follows:

Multiple walled off subphrenic abscess
Generalized pirtenitis
Broncho pneumonia; Bilateral.
(duration) ..... yrs. ..... mos. 23 ds.

CONTRIBUTORY (Secondary) Ruptured gall bladder.
(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? accident,

Did an operation precede death? yes Date of 10/9/30

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy findings.

(Signed) Roland T. Hawkins, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Perring Cem

DATE OF BURIAL 10/13 1930

20 UNDERTAKER J. F. Schaefer

ADDRESS 101 Light

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61254 74-00 E 61254

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST., 7-9 WARD)

2-FULL NAME Celesta Saunders

(a) RESIDENCE NO. 1607 E Monument ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos.

6 DATE OF BIRTH (month, day, and year) March 12-1878

7 AGE: Years 52 | Months 6 | Days 26 | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jos. Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va "

12 MAIDEN NAME OF MOTHER Katie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va "

14 Informant Chas E Butler

(Address) 1607 E Monument

D 1930 .192 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 5 mos. 5 hrs.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No Necessary

What test confirmed diagnosis? Physician

(Signed) ..... (Coroner) M. D.

Oct 5 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cemetery

DATE OF BURIAL: 10/31/30

20 UNDERTAKER: Robert W. Elkins

ADDRESS: 1515 McElderry St

Spec.—1-30—M. & T.—250 Blks.

E 61255

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61255

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 621 S. Pulaski ST. 20-28 WARD

2-FULL NAME Oliver R. Huber

(a) RESIDENCE NO. 621 S. Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced (or) WIFE of HUSBAND of Henrietta D. Smith

6 DATE OF BIRTH (month, day, and year) April 12th 1909

7 AGE — Years 21 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cafe Counter

(b) General nature of industry, business, or establishment in which employed (or employer) Yellow Cab

(c) Name of employer Company 023

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Jacob Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Meiler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Henrietta E. Huber

(Address) 621 S. Pulaski St

Filed OCT 10 1930, 19

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 19 30, to Oct 8th, 19 1930

that I last saw him alive on Oct 8th, 19 30, at 6:10 a.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

several yrs. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Augustine P. Tondalucci M.D.

, 19 (Address) 1618 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Oct 11th 1930

20 UNDERTAKER H. B. Hufnagel — ADDRESS 1532 N. Bello Ave

Spec.—1-30—M. & T.—250 Bks.

E 61256 E 61256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 756 Mc Kewin Ave. (Ward) 47

2-FULL NAME Elizabeth A. Birckhead

(a) RESIDENCE NO. 756 Mc Kewin Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ (HUSBAND of or) WIFE of Samuel Birckhead

6 DATE OF BIRTH (month, day, and year) April 9th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	91	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bessie E. Shannenburg
(Address) 756 Mc Kewin Ave

Filed 10-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 9, 1930, that I last saw h[illegible] alive on Oct 9, 1930, and that death occurred, on the date stated above, at 1150 P m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis with hypertension

(duration) 5 yrs. — mos. — da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Streett M. D.

10/10 1930 (Address) 450 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 10/13/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

E 61257

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 61257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST., 7-13 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Polski

(a) RESIDENCE NO. 712 N. Register ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 48 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Caspar

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER Marie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Records of Balto. City Hospitals

15 C. HAMPSON JONES, M. D. Registrar

10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-30

17 I HEREBY CERTIFY, That I attended deceased from 9-29-30, 19..., to 10-9-30, 19..., that I last saw him alive on 10-9-30, 19..., and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bile ducts

(duration) more than yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Podjet M. D.

10-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL 10/13/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

1-30—M. & T.—100 B—50L

E 61258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61258

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE—No. North av near Denmead ST., 11-26 WARD)

2-FULL NAME Carson L. Kennard

(a) RESIDENCE No. 723 La Fayette Ave & Fremont ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single.

6 DATE OF BIRTH (month, day, and year): Dec 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Funeral Director
(b) General nature of industry, business, or establishment in which employed (or employer): self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Baltis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Anna Carson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: George Carson

(Address) 1810 Rosedale St

15 Filed 11 1930, 192 HAMPTON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9th 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Hemorrhage, due to
Pistol wound, head,
(duration) yrs. Instantaneous

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? North Av near Denmead

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Blunk, M. D. Coroner

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL 10/11/30

20 UNDERTAKER: J. J. Fahey & Sons

ADDRESS 1318 Light

Cor.—10-10-29—A Co.—100 Bks.

E 61259

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61259

CERTIFICATE OF DEATH

170

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 107 W. 29th St. 12-51 St., Ward)

2-FULL NAME Franklin W. Day

(a) RESIDENCE NO. 107 W. 29th St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella Beacham

6 DATE OF BIRTH (month, day, and year) May 18, 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	72	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Newark,
(State or country) N. J.

PARENTS

10 NAME OF FATHER Oliver Beacham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Susan Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New Jersey

14 Informant Mrs. Ella Beacham Day
(Address) 107 W. 29th St.

15 Filed 10-11 1930 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound
Through Head.
(Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Morrissey, M. D.

10/10. 1930 (Address) 963 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Oct. 11, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Place

John O. Mitchell & Sons

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61260 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61260

CERTIFICATE OF DEATH. 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 442 Pasquette ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Mills

(a) RESIDENCE NO. 442 Pasquette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE C | 5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louisa Mills

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE Years 76 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher (Ret'd)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Okonoke Md

PARENTS

10 NAME OF FATHER Isaac Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

14 Informant Louise Mills

(Address) 442 Pasquette

C. HAMPSON JONES, M.D.

Filed 11 1930, 19 RHH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Oct 7, 1930, that I last saw ~~him~~ alive on Oct 7, 1930, and that death occurred, on the date stated above, at 8P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) L. S. Allen, M. D.

10-9, 1930 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL Oct 11 1930

UNDERTAKER Mrs R. A. Elliott

ADDRESS 1745 Woodland

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61261 132 E 61261

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1616 E Monument ST., 7-13 WARD)

2-FULL NAME Minnie Ahart

(a) RESIDENCE NO. 1616 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married.

3a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of Carroll Ahart

6 DATE OF BIRTH (month, day, and year) March 5 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 837

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Orange Va.

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Alice Higgs?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Carroll Ahart husband

(Address) 1616 E Monument St

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9/30

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1930, to 10/9, 1930, that I last saw her alive on 10/8, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pyo-Nephroid & Kidney stone

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia from long bed confinement

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Physical

What test confirmed diagnosis?

(Signed) R. L. Young, M. D.

10/10/30 (Address) 1419 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Orange Va

DATE OF BURIAL Oct 14 1930

20 UNDERTAKER Mrs. A. G. Ekid

ADDRESS 1726 Baltimore

1-30—M. & T.—100 B—50L

E 61262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61262

REGISTERED NO. 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) University Hospital ST. 22-30 WARD)

2-FULL NAME William Brown

(a) RESIDENCE No. 212 S. Greene ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Restaurant Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elmina Brown

(Address) Buffalo N.Y.

Filed Oct 1 1930 C. HAMPSON JONES, M. D. Registrar RCH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoned by illuminating gas

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) yrs. mos 7 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 212 S. Greene St

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Grill, M. D. Coroner

10/9, 1930 (Address) 2739 Edgewood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 10-11 1930

ADDRESS 1400 Mosher

20 UNDERTAKER Jno. R. Chase & Son

Spec.—1-30—M. & T.—250 Bks

E 61263 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61263

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 70-69 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lippy

(a) RESIDENCE NO. 401 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

6 DATE OF BIRTH (month, day, and year) June 7, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Records of Balto. City Hosp.

15 Filed 1 1930 19 C. HAMPSON JONES, M. D. Registrar

Ref.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-30

17 I HEREBY CERTIFY, That I attended deceased from 5-24-30, 19, to 10-9-30, 19, that I last saw him alive on 10-9-30, 19, and that death occurred, on the date stated above, at 10:55 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Myocarditis. Chronic (duration) more than yrs. 5 mos. da.

18 Where was disease contracted if not at place of death? 1. Hospital 2 Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

10-10 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carlwood Lawn

DATE OF BURIAL Oct 13/30

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61264 49 E 61264

CERTIFICATE OF DEATH

1—PLACE OF DEATH

(CITY OF BALTIMORE: (No.) 1711 N. Caroline St., ST.) 8-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lydia S. Roberts

(a) RESIDENCE NO. 1711 N. Caroline Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

6 a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Roberts

7 DATE OF BIRTH (month, day, and year) March 29, 1874

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George T. Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William H. Roberts

(Address) 1711 N. Caroline Street

15 Filed 11 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24th, 1930, to October 9th, 1930, that I last saw her alive on October 9th, 1930, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema (Chronic Myocarditis.)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Bladder.

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms.

(Signed) Amelia E. Link M. D.

10. 1930 (Address) 1717 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Oct. 13, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc.

ADDRESS 125 E. North Ave

Spec.—1-30—M. & T.—250 Bks

E 61265

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61265

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5617 Govane Ave ST. 27-46 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine J Lawson.

(a) RESIDENCE NO. 5617 Govane Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Harry E Lawson.

6 DATE OF BIRTH (month, day, and year): Jan 15th 1884

7 AGE: Years 46. Months 8 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Patrick J. Graven

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Katherine Crowley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mr Harry E. Lawson.

(Address) 5617 Govane Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9th 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to Sept 20, 1930, that I last saw h[illegible] alive on Sept 20, 1930, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows: Chronic Intestinal Neuritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Bares, M. D.

10/10, 1930 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: 10/13/1930

20 UNDERTAKER: John J Cowan & Son.

ADDRESS: 901 Hollins St

Spec.—1-30—M. & T.—250 Bks.

1741348
E 61266

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61266

CERTIFICATE OF DEATH.

REGISTERED NO. 723

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Abramowitz

(a) RESIDENCE NO. Newark N J. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 23; Months; Days; If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenog

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N.J.

PARENTS

10 NAME OF FATHER David

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Gussie Pessomiske

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Records

(Address)

15 Filed 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-11-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-5, 1930, to Oct 11, 1930, that I last saw her alive on Oct 11, 1930, and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-7-30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fred W. Weib M. D.

10/11, 1930 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newark N J

DATE OF BURIAL: Oct 11 1930

20 UNDERTAKER: John C. Miller

ADDRESS: 2435 E Oliver

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61267

CERTIFICATE OF DEATH

90 E 61267

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Pier No. 2 Pratt St. St., 3-4 Ward)

2-FULL NAME Garnett Sunkins.(C)

(a) RESIDENCE NO. 415 S. Dallas St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs.; ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed or divorced
HUSBAND of (XXXXXXXXXX) Rosa Sunkins.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	34	------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER John Sunkins.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Lydia ------(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Rosa Sunkins.(C) wife.
(Address) 415 S. Dallas St.

15 Filed ---, 19--- HAMPTON JONES, M. D. Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

10/10. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chas. Side Va. (Charles Co. Va.)	Oct 12 19 30
20 UNDERTAKER	ADDRESS
J. L. Brown and Son	108 W. Monument St
Chesapeake Steamship Co.	

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61268 E 61268

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3201 Clifford Ave St.) (WARD 45th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia M. Firth

(a) RESIDENCE No. 3201 Clifford Ave WARD Esq. Council

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of: William

6 DATE OF BIRTH (month, day, and year): May 7, 1876

7 AGE: Years 54 | Months 6 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penn

PARENTS

10 NAME OF FATHER: Joseph Hiller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn

12 MAIDEN NAME OF MOTHER: Matilda Carpenter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn

14 Informant: William Firth

(Address): 3201 Clifford Ave

15 Filed 12 1930, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 7th, 1930, to Oct 10th, 1930, that I last saw her alive on Oct. 9th, 1930, and that death occurred, on the date stated above, at 9-15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Myocarditis

Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John F. Alexander M. D.

19 (Address) 1520 Bank Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Oct 13 1930

20 UNDERTAKER: Wm Cook 1215 Park — ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 61269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12-49 49 E 61269

1-PLACE OF DEATH Union Memorial Hosp - Children Ward. REGISTERED NO.

CITY OF BALTIMORE: (No. 33rd & Calvert St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Rollins

(a) RESIDENCE NO. Alaska W. Va. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

7 DATE OF BIRTH (month, day, and year) July 25 1924

8 AGE	6 Years	2 Months	16 Days	If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) Alaska W. Va
(State or country)

10 NAME OF FATHER Charles Rollins.

11 BIRTHPLACE OF FATHER (city or town) Fair View Va
(State or country)

12 MAIDEN NAME OF MOTHER Jessie Dowden

13 BIRTHPLACE OF MOTHER (city or town) Alaska W Va
(State or country)

14 Informant Hospital Record.
(Address)

15 Filed OCT 21 1930 C. HAMDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1930

17 I HEREBY CERTIFY, That I attended deceased from September 4, 19 . to October 11, 19 30.

that I last saw h W alive on October 11, 19 30,

and that death occurred, on the date stated above, at 2.05 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - basal of Cerebrum

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Chronic Otitis Media (duration) 1 yr. mos. 3 mos

18 Where was disease contracted if not at place of death? Alaska W. Va

Did an operation precede death? yes Date of 9-18-30 10-11-30

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Jesse C. Fifer M. D.

10 11 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alaska W. Va

DATE OF BURIAL 10/12 1930

UNDERTAKER Wilkens Cook

ADDRESS 1214 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61270 161-001 E 61270

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3417 Hickory Ave ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby may Elizabeth Maddock.

(a) RESIDENCE NO. 3417 Hickory Ave ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6, 1930

7 AGE	Years	Months	Days 5	If LESS than 1 day, ... hrs. or ..... min.
			4 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER Roberto Silvaey Maddock

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Flossie Lindsay

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant mother
(Address)

15 12-1930 H. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Oct 11, 1930, that I last saw h[illegible] alive on Sunday Oct 9, 1930 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. Alexander Lowry M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cemetery — DATE OF BURIAL: Oct 13 30

20 UNDERTAKER: H. Marshall — ADDRESS: 3539 Falls Rd

Spec.—1-10 21—M&T—1500 Bks.

61271

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 49

E 61271

CERTIFICATE OF DEATH.

REGISTERED NO. 25-72

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkins Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Humphrey S Connell (Scannell)

(a) RESIDENCE NO. 111 Bloomsbury Ave ST. WARD St Ann

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Scannell

6 DATE OF BIRTH (month, day, and year): July 15-1866

7 AGE: Years 64 Months 3 Days 6

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Cornelius Scannell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hannah O Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Ellen Scannell 111 Bloomsbury ave

15 Filed . 19 . MARY E. JONES, M. D. Registrar

Entered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1-11 . 1930 . to Oct 11 . 1930 .

that I last saw her alive on Oct 11th . 19 .

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Shock - post operature -

Hemiplegia - Cerebral embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma - branchial cleft

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Removal of tumor

Did an operation precede death? Yes Date of 10-9-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert Kevan, M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 10/14 1930

20 UNDERTAKER: Chas. B. Graves & Son

ADDRESS: 111 W. Mt. Royal Ave

OCT 12 1930

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61272 — 40 — E 61272

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST. 4-30 WARD)

2-FULL NAME Margaret Dorsey

(a) RESIDENCE NO. Glenwood Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas Dorsey

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Toner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Chas Dorsey
(Address) Glenwood Md.

15 Filed DEC 1 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11/30

17 I HEREBY CERTIFY, That I attended deceased from 10/8/30, 19..., to 10/11/30, 19..., that I last saw her alive on 10/11/30, 19..., and that death occurred, on the date stated above, at 11.50 a m.

The CAUSE OF DEATH* was as follows:

Surgical Shock
Operative Hemorrhage

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Pyosalpynx (Left) Rt. Chronic Salpingitis Pelvic Abscess (duration) 3 yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 10/11/30

Was there an autopsy? No

What test confirmed diagnosis? Phys. Signs & Operation

(Signed) W. D. Varney M. D.

10/11, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bush Park Cem. Found on

20 UNDERTAKER F. M. Snyder

DATE OF BURIAL Oct. 13 1930

ADDRESS Mt. Ave

Spec.—1-30—M. & T.—250 Bks.

Louisa Rinkle ✓

E 61273

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61273

CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Poolesan ST. 24-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Rinkle

(a) RESIDENCE NO. 1401 Rinkle Poolesan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles Rinkle

6 DATE OF BIRTH (month, day, and year) March 17 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer))

(c) Name of employer)

037

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr August Rinkle Son

(Address) 1401 Poolesan St

15 Filed 12 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1930

17 I HEREBY CERTIFY, That I attended deceased from 10. 7. 30, 19..... to 10. 10, 19 30.

that I last saw h alive on 10. 7. 30, 19.....

and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) J. Edward Norris M. D.

(Address) 107 East West

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem — DATE OF BURIAL Oct 13 1930

20 UNDERTAKER Chas. L Sterns — ADDRESS 1301 Fort Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

Infant Cook.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61274

CERTIFICATE OF DEATH.

161-001 V

E 61274

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1113 Biscoe St. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Unknown Infant

(a) RESIDENCE. No. 1113 Biscoe ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 10, 1930.

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
				12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bernie Finley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenkins

12 MAIDEN NAME OF MOTHER Carrie Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie Cook (Address)

15 [illegible] C. HAMPSON JONES, M. D. Registrar

Dec 1 1930

Pat [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10 — 1930. to Oct 10 — 1930.

that I last saw him alive on Oct 10 — 1930.

and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH* was as follows: Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

Oct 11 1930 (Address) 2034 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Oct 3 1930

20 UNDERTAKER Wm. H. Cross & Son

ADDRESS 1400 Madison

Spec.—1-30—M. & T.—250 Bks.

Dr Traband 1219 Poplar Grove St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61275 E 61275

CERTIFICATE OF DEATH.

90

REGISTERED NO. 16-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 Poplar Grove St.) (WARD)

2-FULL NAME Louisa M. Barnes

(a) RESIDENCE NO. 936 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ ~~Husband~~ of or) WIFE of: Walter S.

6 DATE OF BIRTH (month, day, and year) April 2. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	6	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Miles Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Eliza Ann Church

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Md

14 Informant: Ellen C. Riddlake

(Address): 936 Poplar Grove

Filed 12-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 22, 1925, to Oct 11, 1930,

that I last saw her alive on Oct 10, 1930,

and that death occurred, on the date stated above, at 20. m.

The CAUSE OF DEATH* was as follows: General Arterio Sclerosis

(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Myocarditis Oedema

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Opera Glass

(Signed) John A. Fulton M. D.

10/12/19 30 (Address) 12 19 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 10/13/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61276 166 E 61276

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 61276

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9-13 WARD)

2-FULL NAME Mary M.(Jean) Rogers

(a) **RESIDENCE** NO 1044 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harvey H. Rogers Dec 24/1906

6 DATE OF BIRTH (month, day, and year) Dec 24, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	7 9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Leva, Pa.

PARENTS

10 NAME OF FATHER James Madden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harvey H. Rogers

(Address) 1044 N. Broadway

15 Filed ..... 1930 R. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Bichloride Mercury Poisoning. Suicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1242 Orleans St

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) ..... Coroner

Oct 11/30 508 E. North Ave. , 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 10/13 19 30

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Bks

E 61277 HEALTH DEPARTMENT—CITY OF BALTIMORE 120 E 61277

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 273 S. Ellwood ave ST., 1-W WARD)

2-FULL NAME Catherine M Thompson

(a) RESIDENCE NO. 273 S. Ellwood ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced (HUSBAND of or) WIFE of: George W. Thompson

7 DATE OF BIRTH (month, day, and year): July 11, 1882

8 AGE: Years 48 | Months 1 | Days 29 | If LESS than 1 day, ...hrs. or ....min.

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Baltimore Md

11 NAME OF FATHER: Michael Mannion

12 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

13 MAIDEN NAME OF MOTHER: Bridget Cornelia

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

15 Informant: George W. Thompson
(Address): 273 S. Ellwood ave

Filed DEC 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 10, 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to Oct 10, 1930, that I last saw h[illegible] alive on Oct 10, 1930, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Yellow Atrophy of Liver
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood & Laundyer

(Signed) D. Hampson Jones M. D.

19 (Address) 30, S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Oct. 13, 1930

20 UNDERTAKER: John A. Moran

ADDRESS: 3000 E. Balt

Spec.—2-29-28—L. F. S.—500 Bks.

E 61278

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61278

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH Maryland General Hospital REGISTERED NO. 29

CITY OF BALTIMORE: (No. Linden Ave and Madison ST. 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie E Eurby

(a) RESIDENCE NO. 310 N Philadelphia ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W h	S

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 7. 1929.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER August Eurby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER M Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hospital record.
(Address)

15 Filed Oct 13 1930 HAMPSON JONES, M. D. Registrar

OCT 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 10/30

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1930, to October 10, 1930

that I last saw her alive on October 10, 1930

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert X. Clements, M. D.

(Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL Oct 13 1930

20 UNDERTAKER Geo L. Miller & Son

ADDRESS 733 W Lafayette Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Lemdale

CITY OF BALTIMORE: (No. 27-54 ST. WARD)

2-FULL NAME Nathan Lerman

(a) RESIDENCE NO. Lemdale ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 87 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Mrs. Lyman 235 Windermere Ave.

15 Filed OCT 12 1930 J. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-10-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept- , 1929 , to Oct.-10- , 1930 , that I last saw him alive on Oct-10- , 1930 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
hypertension

Not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Herman Sidel, M. D.

10/16 1930 (Address) 2404 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Levi Lyons, Lem

DATE OF BURIAL: 10-12- 1930

20 UNDERTAKER: Lucas Lewis, 1439

ADDRESS: Balto

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61280

CERTIFICATE OF DEATH.

E 61280

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bessie Hurwitz

(a) RESIDENCE NO. 2225 E. Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Isaac Hurwitz

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 3 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Philip Eisman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachael —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs. Isaac Hurwitz

(Address): 2225 E. Balto St.

15 Filed ..., 19 ... Registrar

21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11-30

17 I HEREBY CERTIFY, That I attended deceased from 9-25, 1930, to Oct. 11, 1930, that I last saw her alive on Oct 11, 1930, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

~~Pyelitis (B. Coli)~~

(duration) 4 ? ? yrs. mos ds.

CONTRIBUTORY (Secondary) Pyelo-nephritis - bi-lateral.

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.; Cystoscopy

(Signed) Meeker B. Cusk, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Levy Lodge

DATE OF BURIAL: 10-12-1930

20 UNDERTAKER: Jacob Levy, 1439 E. Balto St.

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 61281

E 61281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 Fleet St. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Nawak

(a) RESIDENCE NO. 2608 Fleet St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) April 1 1930

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		6	9	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leo Nawak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Agnes Marshal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Leo Nawak (Address) 2608 Fleet St

15 Filed OCT 12 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1930 to Oct. 11, 1930, that I last saw h— alive on Oct. 11, 1930, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows*:

Acute Bronchitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

, 19 (Address) 2529 Eastern Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Oct 13 1930
20 UNDERTAKER John M Weber	ADDRESS [illegible]

OCT 12 1930

Spec.—1-30—M. & T.—250 Blks.

E 61282

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61282

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2217 Eastern Avenue ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walenty . Szwarc

(a) RESIDENCE NO. 2217 Eastern Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of Maryanna . Szwarc

7 DATE OF BIRTH (month, day, and year) Feb 7 ~~1872~~ 1872

8 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58 ~~68~~ yrs	8	3	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tallyman for B.O. R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus . Szwarc

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Magdalena. Malas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Maryanna . Szwarc

(Address) 2217 Eastern Avenue

Filed OCT 12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10/30

17 I HEREBY CERTIFY, That I attended deceased from ~~Feb 12~~ 1930, to Oct 10, 1930.

that I last saw h~~i~~m alive on Oct 10, 1930

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of descending colon

7 months (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) B O'Kelly M. D.

, 19 (Address) 102 N. Edmondson Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Oct. 14 1930

UNDERTAKER Peter A Gelbert

ADDRESS 1 Edmondson Ave

~~THOMPSON JONES, M. D.~~

Spec.—1-30—M. & T.—250 Bks

E 61283 ✓ E 61283

E 61283 HEALTH DEPARTMENT—CITY OF BALTIMORE

38

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. University Hospital WARD) 11-20

2-FULL NAME Dora Johnson

(a) RESIDENCE No. 1626 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper 070
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS
10 NAME OF FATHER Benjamin Johnson
11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina
12 MAIDEN NAME OF MOTHER Lillie Kinlaw
13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Freda Johnson
(Address) 1626 McCulloh St

Filed OCT 1 2 1930 C. HAMPSON JONES, M. D. Registrar
By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1930, to Oct 9, 1930, that I last saw her alive on Oct 9, 1930, and that death occurred, on the date stated above, at 9:35 P m.

The CAUSE OF DEATH* was as follows:
Syphilitic liver disease
M D
Unknown duration
(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical findings and autopsy
(Signed) R. C. Hudson, M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interlaken Cem
DATE OF BURIAL 9-13 1930
20 UNDERTAKER Fraser N. Gibson
ADDRESS 1735 Druid Hill Ave

Spec.—1-30—M. & T.—250 Bks

E 61284

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61284

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Mercy Hospital ST. 11-24 WARD)

2-FULL NAME Elma Erich

(a) RESIDENCE NO. 615 Park Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	2	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS
10 NAME OF FATHER Augustus F. Erich
11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)
12 MAIDEN NAME OF MOTHER Emma Buetjer
13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Hospital Records.
(Address)

15 Filed 1-3 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-30

17 I HEREBY CERTIFY, That I attended deceased from 10-1-, 1930, to 10-12, 1930, that I last saw her alive on 10-12, 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 2(?) yrs. mos da.

CONTRIBUTORY (Secondary) Metastasis to lungs (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of Aug 1929
Was there an autopsy? No
What test confirmed diagnosis? Clinical + Ope-
(Signed) J. Leyko, M. D.
11/12, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery
DATE OF BURIAL Oct 13 1930
20 UNDERTAKER Henry Herbert's Sons Co
ADDRESS Orchard & Fort-Calhoun Sts

Spec.—1-30—M. & T.—250 Bks.

E 61285

E 61285

E 61285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 744 Penn. ave ST. 17-23 (WARD)

2-FULL NAME George H. C. King

(a) RESIDENCE NO. 744 Penn ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Henrietta King

6 DATE OF BIRTH (month, day, and year) March - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Princess Anne Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Henrietta King (Address) 744 Penn Ave

15 Filed OCT 3 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct 11, 1930, that I last saw h alive on Oct 10, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 1 mos 11 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. A. Flowers M. D.

Oct 14 1930 (Address) 712 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Oct 14 1930

20 UNDERTAKER Wm H. Grace & Son — ADDRESS 440 Madison

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61286 + 31 E 61286

E 61286

CERTIFICATE OF DEATH.

REGISTERED NO. 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH United States Marine Hospital

CITY OF BALTIMORE: (NO. Baltimore, Md. ST., WARD)

2-FULL NAME 2 1 Hanes, Parker (Parker Hanes)

(a) RESIDENCE NO. 2910 Rendall Ave., ST., Richmond, Virginia WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced (HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Volusia

9 BIRTHPLACE (city or town) (State or country) Richmond, Va.

PARENTS

10 NAME OF FATHER Lewis L. Hanes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maggie Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant U.S. Marine Hospital Records, (Address) Baltimore, Maryland.

15 Filed 1-3 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to October 11, 1930.

that I last saw him alive on October 11, 1930,

and that death occurred, on the date stated above, at 2:35 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic, pulmonary, active.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory findings

(Signed) E. H. Townsend, M. D.

, 19 (Address) U.S. Marine Hospital, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Ft. Lincoln Cem. Md. DATE OF BURIAL Oct. 13, 1930

20 UNDERTAKER Wm. J. McDevitt & Son ADDRESS North & Pa

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E. 61287

CERTIFICATE OF DEATH

61287

REGISTERED NO.

1—PLACE OF DEATH Home for Incurables (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1908 ~~Towne~~ ST., 14-20 WARD)

2—FULL NAME Mrs Frances Foltner

(a) RESIDENCE NO. Christing ~~1908 Towne~~ ST., Royal Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Harold F. Foltner

7 DATE OF BIRTH (month, day, and year) Mar. 13 1854

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	6	28	

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Hamilton-Ont Syracuse New York~~ Canada

10 NAME OF FATHER William H. Wills

11 BIRTHPLACE OF FATHER (city or town) Canada (State or country)

12 MAIDEN NAME OF MOTHER Augusta Boardman

13 BIRTHPLACE OF MOTHER (city or town) Syracuse (State or country) New York

14 Informant Hulbert H. Foltner

(Address) Lusby, Calvert Co. Md.

15 Filed Oct. 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-11-'30

17 I HEREBY CERTIFY That I attended deceased from Oct-7 1930 to Oct 11 1930

that I last saw her alive on Oct 11 1930

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia (duration) — yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

19 Signed Phil B Mayo M. D.

10/11 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middleham Chapel-Md DATE OF BURIAL Oct 13 1930

20 UNDERTAKER W M Proctor & Sons ADDRESS Hyattsville Md

1-3-1930 JONES, H. Registrar

Spec—1-30—M. & T.—250 Bks. Minnie B. McCauley.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61288 E 61288

CERTIFICATE OF DEATH.

109-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (WARD)

2-FULL NAME Minnie McCauley

(a) RESIDENCE NO. 154 West Cross ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph L. McCauley

6 DATE OF BIRTH (month, day, and year): Aug. 6, 1876

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt. Md

12 MAIDEN NAME OF MOTHER: Janette Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt. Md.

14 Informant (Address): Mrs. Grace Bull 460 Kenwick Rd

15 Filed 1930, DAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased ~~from~~ on Oct. 11, 1930 ~~to~~ ....., 19.....,
that I last saw her alive on Oct. 11, 1930,
and that death occurred, on the date stated above, at 6:50 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

Primary: Streptococcic Sore Throat (duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Uremia (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Laboratory and Post Mortem

(Signed) Joseph H. Bishop M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood

DATE OF BURIAL: Oct 15 1930

20 UNDERTAKER: E Hunsworth Son

ADDRESS: 3610 Bluetut

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61289 172-201 E 61289

CERTIFICATE OF DEATH.

E 61289
1-PLACE OF DEATH: Baltimore City Hospitals

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) George W. Wilkinson ST. 1-2 WARD)

2-FULL NAME: George W. Wilkinson

(a) RESIDENCE NO. 415 S. Robinson St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice

6 DATE OF BIRTH (month, day, and year) April 17, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Produce dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS
10 NAME OF FATHER Orlando
11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)
12 MAIDEN NAME OF MOTHER Mary A. Patton
13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant: Records of
(Address) Balto. City Hosp.

15 Filed 1-3 1930 HAMILTON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10-30

17 I HEREBY CERTIFY, That I attended deceased from 9-30-30, 19..., to 10-10-30, 19...,
that I last saw him alive on 10-10-30, 19...,
and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver over
(duration) yrs. 6 mos da.
CONTRIBUTORY (Secondary) Myocarditis, chronic
(duration) yrs. UNKNOWN mos. da.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Paul Padget, M. D.
10-11, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Oct 14, 1930
20 UNDERTAKER: Harry W. Ehlen ADDRESS 1444 W. North Ave

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61290

E 61290

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 1-3 WARD)

2-FULL NAME Joseph Kleczkowski

(a) RESIDENCE No 809 S. Luzerne ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15-1887.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	3	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stenedon pt
(b) General nature of industry, business, or establishment in which employed (or employer) 01
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Ignacy Kleczkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Zofilia Czarska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Mr. Anthony Kleczkowski

(Address) 809 S Luzerne ave.

15 Filed Oct 13 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Embolus- Accidently injured left thumb 3wk. before wh. he at work and infection resulted.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At work

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Heiter, M. D. Coroner

19 (Address) 608 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery

DATE OF BURIAL Oct 14 1930

20 UNDERTAKER George A. Weber

ADDRESS 700 S. Ann st.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61291

E 61291

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3718 Lee. street Wagners Point ST. 25-16 WARD

2-FULL NAME Karol Ihrzee

(a) RESIDENCE NO. 3718 Lee-street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day and year): August 1st. 1928.

7 AGE: Years 2. Months 2. Days 10. If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Ihrzee.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Josefa Izyzka.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant (Address): John Ihrzee 3718 Lee Street

15 Filed OCT 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 11, 1930

that I last saw h[illegible] alive on Oct 11, 1930

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Acidosis

(duration) yrs. mos 5 ds.

(Pneumonia 3 days)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Hosta, M. D.

Oct 11, 1930 (Address) 4700 Kenilworth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cemetery

DATE OF BURIAL: Oct 13 1930

20 UNDERTAKER: George A. Weber

ADDRESS: [illegible]

Spec.—1-30—M. & T.—250 Bks.

2E 1407
2E 61292

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001 E 61292

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 10-14 WARD)

2-FULL NAME Anthony Drozd

(a) RESIDENCE NO. 1040 E Monument St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Single

6a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student MD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Blase Drozd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Nes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Interment Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6 , 1930 to Oct 10 , 1930 that I last saw h alive on Oct 10 , 1930 and that death occurred, on the date stated above, at 10 50 P.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Frumershaus, Md

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture

(Signed) Caroline C. Bedell M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL Oct 15 1930

20 UNDERTAKER George A. Weber

ADDRESS 705 S. Amm st.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61293 (2nd) E 61293

REGISTERED NO. 1-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie James

(a) RESIDENCE NO. 1525 E. Baltimore St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE: Years 17; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. Old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Garfield James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 14 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1930, to Octobr 12, 1930, that I last saw her alive on Octobr 12, 1930, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lung

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary congestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Tissue examination.

(Signed) Caroline C. Bedell, M. D.

Oct 14, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashburn cemetery

DATE OF BURIAL Oct 14 1930

20 UNDERTAKER Edward Bergan

ADDRESS 668 N Orleans St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 61294

REGISTERED NO. E 61294

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 George ST. 17-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Boone

(a) RESIDENCE NO. 814 George ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22-1849

7 AGE: Years 81 | Months | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS:

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Dorsey (Address) 814 George St.

15 Filed 1 1930 C. HAMPSON JONES, M. D., Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1930, to Oct 10 1930, that I last saw him alive on Oct 3 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Left hemiplegia

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) Chas J. Keller M. D.

10/13 1930 (Address) 2226 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL Oct 13 1930

20 UNDERTAKER Samuel Hemsley ADDRESS 578 Pulaski St

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61295

E 61295

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 Evesham ave ST. 27-48 WARD

2-FULL NAME John Randolph Ridgely

(a) RESIDENCE No. 709 Evesham ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Charlotte Asquith Ridgely

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired pol

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Randolph Ridgely

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ball

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Edward B. Stapleton
(Address) 709 Evesham Ave.

15 Filed OCT 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13-30.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Oct 13, 1930, that I last saw him alive on Oct 13, 1930 and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Ch. Nephritis
Chr. Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Decompensation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. V. Bristol, M. D.

Oct 13, 1930 (Address) 501 Sherbourne Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Oct 15 1930

20 UNDERTAKER Chas. S. Black

ADDRESS 742 W. Northave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61296 E 61296

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH 4301 Roland Ave

CITY OF BALTIMORE: (No.) Kirkleigh Villa. ST. 27-49 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Mullen

(a) RESIDENCE NO. Roland Ave. & University Parkway ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Peter Mullen

6 DATE OF BIRTH (month, day, and year) June 25th, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gaffney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Rev. Sister Marie

(Address) Kirkley Ville

15 Filed 13 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1930, to Oct. 12, 1930, that I last saw h[illegible] alive on Oct 11, 1930, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows: Chronic Cardiac dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. F. Hayden M. D.

10/13/1930 (Address) 1216 N. Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery,

DATE OF BURIAL 10/14 1930

20 UNDERTAKER Chas. P. Maus & Son 1180 N. Eutaw

ADDRESS

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61297

E 61297

CERTIFICATE OF DEATH.

118-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST 11-24 WARD)

2-FULL NAME Anna Tipton

(a) RESIDENCE NO. 1122 N Luzerne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of John R Tipton

6 DATE OF BIRTH (month, day, and year) 9/12 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jacob Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barbara Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hospital Records

(Address)

15 Filed 10 13 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11-30

17 I HEREBY CERTIFY, That I attended deceased from 10-10, 1930, to 10-11, 1930, that I last saw her alive on 10-11, 1930, and that death occurred, on the date stated above, at 3-25 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/10/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + operative

(Signed) J. Leyko, M. D.

10/11, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cemetery Cottonbay Pa

DATE OF BURIAL 10/14 1930

20 UNDERTAKER

ADDRESS 1606 N Chester St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

CERTIFICATE OF DEATH

E 61298 REGISTERED NO. E 61298

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp ST., 28-66 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Bantham

(a) RESIDENCE NO. 515 Stamford Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 4 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced: HUSBAND of (or) WIFE of Katherine Bantham

DATE OF BIRTH (month, day, and year) May 28th 1875

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 466

(b) General nature of industry, business, or establishment in which employed (or employer): Wm. G. Albrecht Co

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Charles H. Bantham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Waterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant: John Tressider

(Address) 515 Stamford Rd

Filed OCT 13 1930, 19 ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1930 to Oct 9, 1930

that I last saw him alive on Oct 9, 1930

and that death occurred, on the date stated above, at 9:30 8 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

Acute Endocarditis of Chronic nephritis

(duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Widal Test

(Signed) Harry Lehman, M. D.

(Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Oct 13/30

20 UNDERTAKER: J. B. Wyatt — ADDRESS: 1850 W. Balto St

pec.—1-30—M. & T.—250 Bks.

E 61299

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61299

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 N. Bentalou St., 16-68 WARD)

2-FULL NAME Louis N. Kaufman

(a) RESIDENCE NO. 1226 N Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of Betty Kaufman

7 DATE OF BIRTH (month, day, and year) Aug 5-1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Moses Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adela Hecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lena Baumgarten (Address) 2407 Eutaw Pl

Filed OCT 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10/30

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1930, to Oct. 9th, 1930, that I last saw him alive on Oct. 9th, 1930, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Eye.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Steinberg, M. D.

, 19 (Address) 3735 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 15/30

20 UNDERTAKER E. S. Hepfner ADDRESS 1850 N. Balto St.

Signature of Undertaker

NATSON JONES, M.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61300

E 61300

CERTIFICATE OF DEATH.

REGISTERED NO. 101-60

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) 3031 Mount St. (Ward) 14-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hippler

(a) RESIDENCE NO. 3031 Mount St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mimie L. (Kleinschmidt)

6 DATE OF BIRTH (month, day, and year) March 27-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown Hippler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Minnie L. Hippler (Address) 303 So. Mount St

15 Filed 19 Registrar 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept-10 1930, to Oct 10 1930, that I last saw h in alive on Oct 10 1930, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James N. Heyborn M. D.

10/12 1930 (Address) 1729 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	10/13/30

20 UNDERTAKER Harry A. Wise & Son ADDRESS 4101 Edmondson Ave

13 1930 W 5NOP NOS.1RYH

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61301

100-001

CERTIFICATE OF DEATH.

E 61301

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 713 W. Mulberry ST. 4-76 (WARD)

2-FULL NAME Roxaline V Brown

(a) RESIDENCE NO. 713 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	—

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) Feb 1, 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	10 11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md

(State or country)

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) Richmond

(State or country) Va

12 MAIDEN NAME OF MOTHER Minnie Riney

13 BIRTHPLACE OF MOTHER (city or town) Richmond

(State or country) Va

14 Informant Minnie Brown

(Address) 713 W. Mulberry St

15 Filed 13 1930 H. N. SIMMONS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 12, 1930, that I last saw h alive on Oct 12, 1930, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Primary)

(duration) yrs. mos 4 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Oct 13, 1930

20 UNDERTAKER Mrs. Katie R Williams

ADDRESS 322 N Schroeder St.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 C 61302

E 61303

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 McKean Ave. ST. 16-22 WARD)

2-FULL NAME Mrs. Sarah D. Morris.

(a) RESIDENCE NO. 810 McKean Ave. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Morris

6 DATE OF BIRTH (month, day, and year) Apr. 8, 1866

7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs or ... min.

64. | 6 | 3 |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berlin, Germany

PARENTS

10 NAME OF FATHER — Borchard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Weinrund

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mr. Joshua Morris, Son 810 McKean Ave

15 Filed OCT 3 1930 C. HAMILTON JONES, M. D. Registrar

by .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11/30 .19

17 I HEREBY CERTIFY, That I attended deceased from 9-27-, 1930, to 10-11-, 1930.

that I last saw h... alive on 10-11-, 1930.

and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) all life yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

*Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Amerritt Lore M. D.

10/11, 1930 (Address) 3705 Liberty Hts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

20 UNDERTAKER David Sondheimer Son

DATE OF BURIAL 10/13/1930

ADDRESS 1902 Eastern Ave

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61303 — CERTIFICATE OF DEATH. — 37-001 — E 61303

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Banner

(a) RESIDENCE NO. Ellicott City Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced HUSBAND of —
6b) WIFE of

7 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 1 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ellicott City
(State or country) Md

PARENTS

10 NAME OF FATHER James Banner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eleanor Sands

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Sarah Sands
(Address) Ellicott City Md

Dec 13 1930 — H. HANSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1930, to Nov 13, 1930, that I last saw h— alive on Nov 13, 1930, and that death occurred, on the date stated above, at 7.40 — m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) about 1½ mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Carroll M McClain, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bushy Park Cem.

DATE OF BURIAL: Oct 14 1930

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City Md

Spec.—1-30—M. & T.—250 Bks

E 61304 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61304

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hughes

(a) RESIDENCE NO. 875 W. Fairmount Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Elizabeth

7 DATE OF BIRTH (month, day, and year): 1860

8 AGE — Years: 70 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Waite Co. N. C.

PARENTS

10 NAME OF FATHER: Benjamin

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Henrietta ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Records of Balto. City Hosp.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

131930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-10-30

17 I HEREBY CERTIFY, That I attended deceased from 10-9-30, 19 to 10-9-30, 19

that I last saw him alive on 10-9-30, 19

and that death occurred, on the date stated above, at 11:40 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) moyethan 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) unknown yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

10-11, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel cem

DATE OF BURIAL: 10-13 19 30

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Eo ave.

1-30—M. & T.—100 B—50L

E 61305

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61305

CERTIFICATE OF DEATH

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1437 N. Pine St. (Ward) 16-22

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Robinson

(a) RESIDENCE NO. 1437 N. Pine St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fm	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant John Robinson
(Address) 1437 N. Pine St.

15 Filed Oct 13 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary) Paralysis (duration) yrs. 3 mos ds.

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) C. Hamilton Jones, M. D. Coroner

19 (Address) Oct 11

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lloyd Garden

20 UNDERTAKER Lloyd Carter

DATE OF BURIAL 10-13 1930

ADDRESS 916 Park Ave

Rec.—1-30—M. & T.—250 Bks.

E 61306

E 61306 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 223 Myrtle Ave (WARD) 7-Na

2-FULL NAME John Scott

(a) RESIDENCE NO. 223 Myrtle Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Josephine Scott

7 DATE OF BIRTH (month, day, and year) July 2 - - 1886

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Georgia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Josephine Scott

(Address) 223 Myrtle Ave

15 Filed OCT 13 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to Oct 11, 1930, that I last saw him alive on Oct 10, 1930, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

a Carcinoma of Common Bile Duct (duration) 1 yrs. 7 mos ... ds.

CONTRIBUTORY (Secondary) c Heart failure (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Aug. 1929

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Howells M. D.

19 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Ann — DATE OF BURIAL 10-13 1930

20 UNDERTAKER Hamel Eaves — ADDRESS 916 Pine

1-30—M. & T.—100 B—50L

E 61307

HEALTH DEPARTMENT—CITY OF BALTIMORE

148

E 61307

CERTIFICATE OF DEATH

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Providence Hosp ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Ideal Reguis

(a) RESIDENCE NO. 509 W Biddle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eric Reguis

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Eric Reguis

(Address) 509 W Biddle

15 Filed ..... 19..... HAROLD JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia

..... (duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Child birth

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... Coroner, M. D.

Oct 10 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Summerlea

20 UNDERTAKER David Easter

DATE OF BURIAL 10-13-30

ADDRESS 916 Pine

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61308 × 129 E 61308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 2 W. 33 ST. WARD OF

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi W. Chaney

(a) RESIDENCE NO. Odenton, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1¼ mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced (~~HUSBAND OF~~ or) WIFE of John S. Chaney

6 DATE OF BIRTH (month, day, and year) April 17, 1884

7 AGE: Years 46 | Months 5 | Days 25 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Odenton Anne Arundel Co., Md

PARENTS

10 NAME OF FATHER P. Franklin Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Odenton Maryland

12 MAIDEN NAME OF MOTHER Parthenia Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Odenton Maryland

14 Informant Hospital records

(Address)

15 Filed 1 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1930, to October 12, 1930, that I last saw her alive on October 12, 1930, and that death occurred, on the date stated above, at 5¹⁵ P. m.

The CAUSE OF DEATH* was as follows:

Hypertensive cardio-vascular-renal disease

(duration) yrs. 1¾ mos 4 ds.

CONTRIBUTORY (Secondary) acute cerebral hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical records

(Signed) Joseph P. Laukaitis, M. D.

, 19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Odenton, Md — DATE OF BURIAL Oct 15 19 30

20 UNDERTAKER Wm J Tuckner Sons — ADDRESS N. Y Pa

Spec.—1-30—M. & T.—250 Bks

61309

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-00

E 61309

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3300 Brentwood Ave (WARD) 42-49

2-FULL NAME Ada Dyer

(a) RESIDENCE NO. 3300 Brentwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): S

6 If married, widowed, or divorced (a) HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1878

8 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer): 670

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town) (State or country): unk

12 MAIDEN NAME OF MOTHER Rebecca Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Louise Holaday 3300 Brentwood

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1930, to Oct 10, 1930, that I last saw h alive on Oct 10, 1930, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Goitre Ulcer perforated (duration) yrs. 5 mos. ds. (over)

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) Louise E. Allen, M. D.

, 19 (Address) 5508 Gainsboro

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cuba Md — DATE OF BURIAL: Oct 13, 1930

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1125 Asbury

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 61310

CERTIFICATE OF DEATH

61310

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Light ST. 22334 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Schalitzky

(a) RESIDENCE NO. 1604 Light ST., 23rd WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced,~~ (write the word)
Female	White	married

6a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William J. Schalitzky

7 DATE OF BIRTH (month, day, and year) May 1st 1872

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER John Mc Gee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Budget McGee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs Bertha Haynes

(Address) 1604 Light St.

Filed OCT 13 1930 C. HAMPSON JONES, M. D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 - 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to Oct 11, 1930, that I last saw h.. alive on Oct 11, 1930 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma right ovarian cyst

Had about 3 yrs (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Gen Carcinomatosis & intestinal obstruction (duration) Oct 1 to 11 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? yes Date of 5 mths

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) W Wallace Wackes, M. D.

, 19 (Address) 910 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Oct 14 1930

20 UNDERTAKER J. A. Kleinkopf

ADDRESS 703 Ha...

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61311

REGISTERED NO. E 61311

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Union Square St. (Ward) 14-28

2-FULL NAME Henry L Grove

(a) RESIDENCE NO. 300 S. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	43	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) 034
(c) Name of employer —

9 BIRTHPLACE (city or town) —
(State or country)

PARENTS

10 NAME OF FATHER John R Grove
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Henry Grove Jr
(Address) 300 S Stricker St

15 Filed 13 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.
The CAUSE OF DEATH* was as follows:
Suicide - Pistol shot in head

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. O'Brooke M. D.
Oct 12. 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL 10/15 1930

20 UNDERTAKER Robert Brooke & Son — ADDRESS Cathedral & Hollins

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61312

90 E 61312

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 602 Truxton St. St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Stainback.(C)

(a) RESIDENCE NO. 602 Truxton St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ~~mos.~~ How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, ~~XXXXXXXXXXX~~ HUSBAND of ~~(XXXXXXXXX~~ Susie Stainback.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	28	———	———	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Alfred Stainback.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Suellen Benford.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Susie Stainback.(C) wife.
(Address) 602 Truxton St.

15 Filed ..... C. HAMILTON JONES, M. D. Registrar

131930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Gemhardt M. D.

10/13 1930 (Address 1017 E. Charles St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	10/15/30
20 UNDERTAKER	ADDRESS
Paul J Hanley	518 N Bond

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61313

CERTIFICATE OF DEATH.

74-001

E. 61313

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 630 E 37th St. 9-47 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Imulkern

(a) RESIDENCE NO. 630 E 37th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Widow

6 If married, widowed, ~~divorced~~ of) WIFE of John Imulkern

7 DATE OF BIRTH (month, day, and year) Apr 30-1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City Bleitler

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER dontshow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Deegan

(Address) 1336 E 37th St

15 Filed OCT 31 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1930, to Oct 11, 1930, that I last saw h.er alive on " 10, 1930, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chas. P. Mees, M. D.

10/31/30, 19 (Address) 408 Cath Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem

UNDERTAKER Geo. E. Mosher

DATE OF BURIAL Nov 14 1930

ADDRESS 300 E Balto St.

Ga Morgan

James Moody

...ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

75-001

61314 E 61314

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4010 Penington Ave. ST. 25-77 WARD)

2—FULL NAME James Moody.

(a) RESIDENCE NO. 4010 Penington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Moody.

DATE OF BIRTH (month, day, and year) Nov. 16, 1856.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	73,	10.	25.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know.

Informant Mary E. Moody.

(Address) 4010 Penington Ave.

Filed OCT 13 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11-1015pm

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1930, to Oct 11, 1930

that I last saw h[e] alive on Oct 11, 1930

and that death occurred, on the date stated above, at 10.15p m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) M. L. Lichtenberg M. D.

10/14/1930 (Address) 2224 Madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodstock Cem DATE OF BURIAL Oct 14, 1930

20 UNDERTAKER A. Howard Evans ADDRESS 88 E. Fayette

...ec.—2-29-28—L. F. S.—500 Bks.

61315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61315

REGISTERED NO. 46

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 Aisquith ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sr. M. Floriana Margaret Hofmann

(a) RESIDENCE NO. Notre Dame Convent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) January 17 1880

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	50	8	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer Sisters of Notre Dame

BIRTHPLACE (city or town) (State or country) New York

10 NAME OF FATHER Lars Hofmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Schuler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Sisters of Notre Dame

(Address)

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-1930

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1929, to October 12, 1930, that I last saw h... alive on October 12, 1930, and that death occurred, on the date stated above, at 9:50 P. M.

The CAUSE OF DEATH* was as follows:

Abdominal Carcinoma

(duration) yrs. 19 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) J. J. Kirby, M. D.

Oct 13, 1930 (Address) 1106 Mott Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Abd DATE OF BURIAL Oct 14 1930

20 UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay St

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61316

E 61316

CERTIFICATE OF DEATH.

118-001

13-59 WARD

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST. WARD

2-FULL NAME Carl William Schilling

(a) RESIDENCE NO. 2337 Linden Ave. WARD 11

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Louise W. Schilling

7 DATE OF BIRTH (month, day, and year) July 1, 1886

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Travelers Insurance Co

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William C. Schilling

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda E. Schauer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Matilda E. Schilling (Address) 2337 Linden Ave.

15 FILED OCT 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13/30

17 I HEREBY CERTIFY, That I attended deceased from 10/5, 1930, to 10/13, 1930, that I last saw h alive on 10/13/, 1930, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Strangulated Diaphragmatic Hernia

Due to Acute Alcoholism,

CONTRIBUTORY (Secondary) (duration) yrs. mos. 6 da. Lobar Pneumonia (duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/5/30

Was there an autopsy? Yes

What test confirmed diagnosis? Exam. chi

(Signed) George Yeager, M. D.

(Address) University Hospital. 10/13/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

UNDERTAKER Woodlook

DATE OF BURIAL Oct. 15 1930

ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 61317

E 61317

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4611 Roland Ave ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles E. Allen

(a) RESIDENCE NO. 4611 Roland Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Eleanor T. Allen

DATE OF BIRTH (month, day, and year) April, 28" 1861

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69	5	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Petersburg, Va.

10 NAME OF FATHER Charles E. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER ~~Panther~~ Burwell Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Charles H. Roloson

(Address) 5301 Spring Lake Way

Filed OCT 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October, 11" 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept - 12, 1930, to Oct - 11, 1930, that I last saw h[illegible] alive on Oct - 11, 1930 and that death occurred, on the date stated above, at 5.15 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Left Hemiplegia

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 1+ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. Ihon Porter, M. D.

10/12 1930 (Address) 4822 Roland Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 14" 1930
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W. Baltimore

1-30—M. & T.—100 B—50L

E 61318

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61318

CERTIFICATE OF DEATH

REGISTERED NO. 166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mowhawk & Thorpe ST. 28 WARD 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Norman Milburn

(a) RESIDENCE NO 4705 Norwood Av ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah L.

6 DATE OF BIRTH (month, day, and year) Jan 21 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	9	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Grocer
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Morris Milburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah L [illegible] (Address) 4705 Norwood

15 [illegible] 42 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Mowhawk & Thorpe

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D. Coroner

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Poplar Hill Md DATE OF BURIAL 10/13 1930

UNDERTAKER Engel & Fahey ADDRESS Fulton & Fayette

pec.—1-30—M. & T.—250 Bks.

E 61319

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61319

CERTIFICATE OF DEATH.

REGISTERED NO. 185

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Union Memorial Hospital (WARD) 11-15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs John Carroll (Mary) R

(a) RESIDENCE NO. 6 E Read St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Mr John Carroll

DATE OF BIRTH (month, day, and year) Oct 10, 1860(?)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70		2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Annie Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

4 Informant Hospital Records (Address)

5 FILED OCT 14 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 21st, 1930, to Oct 12, 1930, that I last saw h alive on Oct 12, 1930, and that death occurred, on the date stated above, at 10 17 P m.

The CAUSE OF DEATH* was as follows:

Fracture neck of femur

Fall

Accidental

Dr H. Coroner Dr Mooney.

(duration) yrs. mos 2 0 ds.

CONTRIBUTORY (Secondary) Pulmonary embolus?

(duration) yrs. mos. 5 hrs ds.

18 Where was disease contracted if not at place of death? Baltimore?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray

(Signed) Ralph J. Hitts M. D.

6/12 1931 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Oct 15 1930

UNDERTAKER Henry W Jenkins & Son — ADDRESS Eutaw & Mt Holly Sts

Spec.—1-30—M. & T.—250 Bks

E 61320

61320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3211 O'Donnell ST. 46-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Jackson

(a) RESIDENCE NO. 3211 O'Donnell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of George Jackson

DATE OF BIRTH (month, day, and year) Nov. 12. 1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	11	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Leesburg Va.

10 NAME OF FATHER Henry Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs Lula Gross

(Address) 3211 O'Donnell St.

15 Filed OCT 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12-1930

17 I HEREBY CERTIFY, That I attended deceased from August 27. 1930. to October 12. 1930.

that I last saw her alive on October 11. 1930.

and that death occurred, on the date stated above, at 5-05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uerus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) I. B. Brenushas, M. D.

(Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leesburg, Va.

DATE OF BURIAL Oct 15 1930

20 UNDERTAKER George W. Zimbler

ADDRESS 1737 E. Eager St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61321 — CERTIFICATE OF DEATH — 112 E 61321

1—PLACE OF DEATH Maryland General Hospital — REGISTERED NO. 9-46

CITY OF BALTIMORE: (No. ____ ST., ____ WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Corrine Garrety

(a) RESIDENCE NO. 705 E 30th ST., ____ WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ____ mos. ____ ds. How long in U. S., If foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	S.

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 8, 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1 yea	4	2.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER John Garrety

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Nettie Solloway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore, Maryland

Informant Father.

(Address) 705 E. 30th St

Filed OCT 14 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from September 8, 1930, to Oct 13, 1930, that I last saw her alive on October 13, 1930 and that death occurred, on the date stated above, at 3:40 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(duration) yrs. 5 mos. 4 ds.

CONTRIBUTORY (Secondary) ____ (duration) yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert V. Ellsworth M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Com — DATE OF BURIAL 10/16 1930

20 UNDERTAKER Wm Cook — ADDRESS 1317 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 61322

E 61322 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Maryland Penitentiary Hospital (WARD)

2—FULL NAME Sherman Hudson

(a) RESIDENCE NO. 705 Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Pulley

DATE OF BIRTH (month, day, and year) April 13, 1904

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	26	5	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pasadena Md.

10 NAME OF FATHER Geo. Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh N.C.

12 MAIDEN NAME OF MOTHER Dora Brantford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Raleigh N.C.

Informant Dora Hudson

(Address) Pasadena Md.

Filed 19 Registrar

C. HAMPSON JONES, M.

T T 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Oct 11, 1930

that I last saw h[illegible] alive on Oct 11, 1930

and that death occurred, on the date stated above, at 9.25 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. 22 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Chas Wm Edwards, M. D.

, 19 (Address) 774 Alameda Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Carleigh Heights

DATE OF BURIAL 10-14-1930

20 UNDERTAKER

ADDRESS

For Chas. G. Bailey 1424 Jefferson st

Spec.—8-16-29—L. F. S.—100 Bks.

E 61323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 61323

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) 192 Druid Hill Ave (ST.) (WARD)

2—FULL NAME Mary E Cooper

(a) RESIDENCE NO. 1921 Druid Hill Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Oscar Cooper

DATE OF BIRTH (month, day, and year): June 17 1870

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	3	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (City or town) (State or country): Charlestown Md

10 NAME OF FATHER: Henry Mayo

11 BIRTHPLACE OF FATHER (City or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Hannah Bowers

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Charlestown Md

Informant: Sarah C Hutchins

(Address) 1921 Druid Hill Ave

Filed 14 1930 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-12-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Oct 12th, 1930, that I last saw her alive on Oct 12, 1930, and that death occurred, on the date stated above, at 12 Noon M.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

PARENCHYMATOUS NEPHRITIS

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What (est confirmed diagnosis): Typical Examination

(Signed) O. H. Hall, M. D.

, 19 (Address) 1266 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlestown Md

DATE OF BURIAL: Oct 14 1930

UNDERTAKER: Emma E Wright

ADDRESS: 701 N Caroline Balto

Cor.—10-10-29—A Cn.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61324

CERTIFICATE OF DEATH

E 61324

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1 Grace Balto G. Hosp (St.) (Ward)

2-FULL NAME Essie Hefner

(a) RESIDENCE NO. 646 Perkins Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12 1910

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	20			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal Oil
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) La

PARENTS

10 NAME OF FATHER Walter Hefner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) La

12 MAIDEN NAME OF MOTHER Ebest Latrau

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) La

Informant Walter Hefner

(Address) 646 Perkins Ave

Filed 1 1930 HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto in which he was riding collided with bank abutment

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Face Mandible Fract Skull (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Franklintown Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Fraum, M. D.

(Address) 29 29th E Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary

DATE OF BURIAL Oct 14 1930

20 UNDERTAKER John H Frazier

ADDRESS 1027 Hanover

spec.—1-30—M. & T.—250 Bks

E 61325 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 61325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. ..... ST., 6-9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Buck Hayes or Robert (Buck) Hazel.

(a) RESIDENCE NO. 1525 E Fayette St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored.	Widowed.

If married, widowed, or divorced
~~(a) WIFE of~~ HUSBAND of Mary.

DATE OF BIRTH (month, day, and year) unknown.

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Eastern Shore of Maryland.

10 NAME OF FATHER Robert Hazel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Frances ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Records of BALTIMORE CITY HOSPITALS

15 Filed OCT 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1930, to Oct. 11, 1930, that I last saw him alive on Oct. 11, 1930, and that death occurred, on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum.

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Hypertension (duration) UNKNOWN. yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

10-12, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	oct 14 1930
20 UNDERTAKER Edward Bryan	ADDRESS 1631 orleans st

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

61326

CERTIFICATE OF DEATH.

1001

122 E 61326

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 2526 Hartford Ave St., 46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Scharding

(a) RESIDENCE No. 2526 Hartford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Sophia Scharding

DATE OF BIRTH (month, day, and year) Nov 17- 1863

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	10	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Rigger

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Sweden

10 NAME OF FATHER Olive Scharding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Mt. Grove.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Sophia Scharding

(Address) 2526 Hartford Ave

Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 8 - , 1930, to October 11, 1930, that I last saw him alive on October 11 - , 1930, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Generalized.
Hepatic cirrhosis.
Ascites.

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs + symptoms

(Signed) Geo. J. Heuga, Jr. M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwarz's Cem

DATE OF BURIAL Oct 14, 30

20 UNDERTAKER Geo M. Enik Son

ADDRESS 811 N Wolfe

HARRISON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61327

E 61327

CERTIFICATE OF DEATH

181-001

76-37

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. ..... Ward)

2-FULL NAME William Twigg

(a) RESIDENCE NO. 4306 E. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 0 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida Twigg

6 DATE OF BIRTH (month, day, and year) Sept 17, 1878.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52	0	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) .....
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Twigg

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Amanda McCready

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Mrs Ida Twigg
(Address) # 4306 E. Lombard St.

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

OCT 4 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigated (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Toxaemia from Illuminating Gas accident

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

10/13/1930 (Address) 700 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	10/15/1930

20 UNDERTAKER John J. Cowan & Son ADDRESS 701 Hollins St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61328

CERTIFICATE OF DEATH

E 61328

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. York Rd. & Rossiter Ave. St. 27-45 Ward)

2-FULL NAME Ralph A. Poole

(a) RESIDENCE NO. 4904 York Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Helen Richardson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Chemical Company
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Ralph A. Poole

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER
Clara Harriman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Helen R. Poole
(Address) 4904 York Road

15 Filed [illegible] 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fracture of Skull.
Struck by Car & run over.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Oct. 14 1930 (Address) 2002 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Oct. 14 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Place

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61329

E 61329

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 848 Whitmore Ave., ST. 16-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ophelia A. Rollins,

(a) RESIDENCE NO. 848 Whitmore Ave., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Washington Rollins

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Frances Hardes

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mr. Rosson.

Address 848 Whitmore Ave.,

Filed OCT 14 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12-30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Oct 11, 1930,

that I last saw h alive on Oct 11, 1930

and that death occurred, on the date stated above, at 7.15 m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Infection

Intramu

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

10/13, 1930 (Address) 541 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct. 14 1930

20 UNDERTAKER: Chas. E. Franck — ADDRESS: 802 Madison Ave.

pec.—1-30—M. & T.—250 Blks

E 61330

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61330

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO.) ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Travis Smith

(a) RESIDENCE NO. 1629 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Jannie

DATE OF BIRTH (month, day, and year) Aug. 7, 1900

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Whitestone

(State or country) Va.

16 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Vina Waters

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 10 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-30

17 I HEREBY CERTIFY, That I attended deceased from 10-8-30, 19..., to 10-9-30, 19...,

that I last saw him alive on 10-9-30, 19...,

and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padgett, M. D.

10-11, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 10/14/30

UNDERTAKER E. Williams & Sons

ADDRESS Eldorado St

pec.—1-30—M. & T.—250 Blks

61331 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61331

CERTIFICATE OF DEATH.

#5

REGISTERED NO.

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 1220 E Preston ST. 9-18 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Ella J. Busick

(a) RESIDENCE NO. 1220 E. Preston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 65 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced
~~HUSBAND of~~ or) WIFE of Charles A. Busick

DATE OF BIRTH (month, day, and year) March 7 1865

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	7	6	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife. 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER John A. Stritt

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Adelina C. Burkard

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mr. Chas A. Busick
(Address) 1220 E Preston St

15 Filed OCT 14 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 - 1930

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1930, to Oct. 13, 1930, that I last saw her alive on Oct. 13 1930, and that death occurred, on the date stated above, at 10. A. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of large intestine

(duration) 1 yrs. 6 mos - ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) S. Lee Magness, M. D.
10/13, 1930 (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Park Cemetery — DATE OF BURIAL: Oct. 16 1930

20 UNDERTAKER: Henry Hoen Sons Inc. — ADDRESS: 1301 E. Eager St

pec.—1-30—M. & T.—250 Bks

61332

E 61332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 N. Howard ST. 11-24 WARD)

2-FULL NAME Henry C. Andrews

(a) RESIDENCE NO. 837 N. Howard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Carrie Andrews

DATE OF BIRTH (month, day, and year) Nov 16/1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal

(b) General nature of industry, business, or establishment in which employed (or employer) Worker

(c) Name of employer Himself

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John A. Andrews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Arabella Earle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie Andrews

(Address) 837 N. Howard St

Rec'd OCT 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1930, to Oct 12, 1930,

that I last saw him alive on Oct 11, 1930,

and that death occurred, on the date stated above, at 12 mid night m.

The CAUSE OF DEATH* was as follows:

CHRONIC INTERSTITIAL NEPHRITIS

(duration) Not known yrs. mos. ds.

CONTRIBUTORY (Secondary) PULMONARY TUBERCULOSIS (duration) Not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis & Physical Exam.

(Signed) C. C. Hoffmann, M. D.

, 19 (Address) 8 East Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London PK

DATE OF BURIAL Oct 14/30 19

20 UNDERTAKER Philip Henrig

ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 61333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 61333

8-17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1411 N. Caroline ST. (WARD)

2—FULL NAME Ella Coleman Richards

(a) RESIDENCE NO. 1411 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX —

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Walter L. Richards

DATE OF BIRTH (month, day, and year) Nov 23, 1890

AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
39		10	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Charles O Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER S. Almira Haynie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant W. L. Richards

(Address) Edgewood Arsenal, Md.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12/930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930 to Oct 12, 1930

that I last saw h alive on Oct 12, 1930

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Parkinsons Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Osteoma —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Phillipsburg Md.

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical

(Signed) J. Walker Thomas M. D.

Oct 13 1930 (Address) 1228 Mercantile

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Oct 14, 1930

20 UNDERTAKER H. K. McComas

ADDRESS Abingdon Md

Cor.—10-10-29—A Co.—100 Bks.

E 61334

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 61334

CERTIFICATE OF DEATH Dunn.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospitals St., 70-69 Ward)

2-FULL NAME Charles (Henry) Dunn

(a) RESIDENCE NO. 210 Ramsay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Dunn

6 DATE OF BIRTH (month, day, and year) Oct 3 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	53	—	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stonecutter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hillgartners

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Bernard Dunn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Schlunk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Emma M Dunn
(Address) 210 S HAMPDEN, JOHNS. M.

15 Filed Oct 17 1930 Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lock jaw, Acute alcoholism

Intemperate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

10 12 1930 (Address) 2002 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 14 1930
20 UNDERTAKER George L. Schwab	ADDRESS 2201 Eutaw Pl.

Spec.—1-30—M. & T.—250 Bks

E 61335

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61335

CERTIFICATE OF DEATH.

X 91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 619 W. Franklin ST. 17-25 WARD)

2-FULL NAME Dr. Meinard A. Menke

(a) RESIDENCE NO. 614 3rd St N.W. Wash ST. D.C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Oct. 5. 1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	0	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Washington D.C.

10 NAME OF FATHER Meinard A. Menke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ely E. Eichorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Menke (Address) 614 3rd St. N.W. Wash. D.C.

15 Filed 1-4 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1930 to Oct 12 1930 that I last saw h[illegible] alive on Oct 12 1930 and that death occurred, on the date stated above, at 11.03 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. 3 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & examination

(Signed) Joseph J. Kneeland M. D.

19 (Address) 2719 Lendenstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cem Wash D.C. DATE OF BURIAL Oct 15 1930

20 UNDERTAKER Wm. J. Ulmer & Sons ADDRESS North Pa

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61336

1-PLACE OF DEATH

City of Baltimore: (No. 1417 Bounty Lane St., 3-4 Ward)

2-FULL NAME Edward Wright

(a) RESIDENCE NO. 1417 Bounty Lane St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

66

E 61336

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, ~~Married~~, ~~Widowed~~ or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant
(Address)

15 Filed ..... 19..

G. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inanition & Exposure

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? [illegible]

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lawrence M. Taylor, M. D.

Oct 13 19 30 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL Oct 30

20 UNDERTAKER Edward Bryan

ADDRESS 1830 Orleans St

Cor.—10-10-29—A Co.—100 Bks.

E 61337

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-002

E 61337

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1115 Peach Alley. St. 23-31 Ward)

2-FULL NAME Dorothy Snowden.(C)

(a) RESIDENCE NO. 1115 Peach Alley. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widnwed or Divorced, (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE nf ———

6 DATE OF BIRTH (month, day, and year) July 12, 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	0	3	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession nr particular kind of work None.
(b) General nature nf industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Snowden.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Della Brightford.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant William Snowden.(C) father.
(Address) 1115 Peach Alley. JONES, M. C.

15 Filed ..... 1930 ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 12, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.

Congenital.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

10/14 19 30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion et	Oct 14 1930
20 UNDERTAKER	ADDRESS
H L Brown & Son	1017 W. Mt.

pec.—1-30—M. & T.—250 Bks

E 61338

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61338

CERTIFICATE OF DEATH.

REGISTERED NO. 51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3812 Tait Ave ST. 26 WARD)

2-FULL NAME Michael Gast.

(a) RESIDENCE NO. 3812 Tait ave ST. 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Gast.

DATE OF BIRTH (month, day, and year) Feb. 15 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	8	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margt. ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Eva Gast (Wife)

(Address) 3812 Tait ave.

Filed ... 19 ... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from January, 1930, to Oct 11, 1930, that I last saw h. alive on Oct 10, 1930, and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Endocarditis

(duration) ... yrs. ... mos ? ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) H. H. Kaufelmeier, M. D.

Oct 13 1930 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL Oct 15 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 4033 S. Wolfe St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61339 ✓ E 61339

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5219 Windsor Mill (St.) 25th (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Muth

(a) RESIDENCE NO. 5219 Windsor Mill Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah C. Muth

6 DATE OF BIRTH (month, day, and year): Feb. 14 1861

7 AGE — Years: 69 — Months: 7 — Days: 27 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired of 13

(b) General nature of industry, business, or establishment in which employed (or employer): Butcher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md!

PARENTS

10 NAME OF FATHER: Eugene Muth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Clara Belz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Hannah C. Muth

(Address): 5219 Windsor Mill Rd.

Filed Oct 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 11, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1929, to Oct 11, 1930.

that I last saw him alive on Oct 11, 1930

and that death occurred, on the date stated above, at 2.25 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) A. C. Lamb, M. D.

(Address) 1409 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cemetery — DATE OF BURIAL: Oct. 15 1930.

20 UNDERTAKER: John F. Kenney — ADDRESS: 715 Light St.

pec.—1-30—M. & T.—250 Bks.

E 61340 384
241

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61340

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Whitehead

(a) RESIDENCE NO. 1529 Baldwin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	—

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Sept 14-1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maggie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M. D.

Registrar

14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Oct 13, 1930, that I last saw h[illegible] alive on Oct 13, 1930, and that death occurred, on the date stated above, at 7 20 p m.

The CAUSE OF DEATH* was as follows:

Entrocolitis + Diarrhoea

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Sublingual + Submaxillary abscess

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ....

Was there an autopsy? Yes

What test confirmed diagnosis? ....

(Signed) J. C. Goodwin, M. D.

10/14 1930 Address Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden

DATE OF BURIAL Oct 15 1930

20 UNDERTAKER Thesow & Son

ADDRESS 3615 Chestnut Ave

Spec.—1-30—M. & T.—250 Bks

E 61341

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61341

CERTIFICATE OF DEATH.

159-002

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital ST. 13-57 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME John Ward

(a) RESIDENCE NO. 1228 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 1, 1928

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2 yrs		12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER William R. Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Rose M. King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

Informant Hospital Record

(Address)

C. HAMPSON JONES, M. D. Registrar

Oct 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/8/30, 19..., to 10/13/30, 19...,

that I last saw h.. alive on 10/8/30, 19...,

and that death occurred, on the date stated above, at 3.00 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Congenital Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1228 Harlem Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Chambers, M. D.

Oct 13 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

DATE OF BURIAL Oct 15 1930.

ADDRESS 3615 Elmwood Ave

20 UNDERTAKER Ebenezer Lee

Spec.—1-10-21—M&T—1500 Blks.

E 61342

E 61342 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Nursing & Calvert Sts. (Ward) 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Brooke

(a) RESIDENCE No. 4637 Park Heights Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Brooke

6 DATE OF BIRTH (month, day, and year) June 6, 1889

7 AGE 41 Years 4 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Loessel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Anna Schroder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Hattie Brooke

(Address) 4637 Park Heights Ave

OCT 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1930 to Oct. 13 1930.

that I last saw h alive on Oct 13, 1930.

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tbc - c hepatitis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis Chronic Interstitial

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home Fields in Ams

Did an operation precede death? Yes Date of 9 22 30.

Was there an autopsy? No

What test confirmed diagnosis? Lab. Test.

(Signed) Hjalmar S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Oct. 16, 1930

20 UNDERTAKER Martin Fahey & Sons

ADDRESS 1827 W. North Ave

Spec.—1-30—M. & T.—250 Bks.

E 61343 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61343

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 E. Chase ST. 10-1 WARD)

2-FULL NAME Edward J. Connelly

(a) RESIDENCE NO. 916 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of the late Nora Connelly (or) WIFE of nee Ryan

DATE OF BIRTH (month, day, and year) May 29 1876

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
54		5	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work News Stand

(b) General nature of Industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Thomas Connelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. John J. O'Connor (Address) 916 E. Chase St

15 Filed 4 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/12/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1929, to Oct 11th 1930, that I last saw h[illegible] alive on Oct 11th 1930, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Tankard, M. D.

, 19 (Address) 1192 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 15, 1930

20 UNDERTAKER Edward W. Conklin ADDRESS 924 E Eager

1-30—M. & T.—100 B—50L

E 61344

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61344

CERTIFICATE OF DEATH

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Conrad

(a) RESIDENCE NO 4310 Kinslie Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24/1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9	7	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Josephine Dvorak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant James Conrad
(Address) 4310 Kinslie Ave

15 4 1930 Oct 16 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ruptured Appendix

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Oct 12/30

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Green, M. D. Coroner

19 (Address) 508 E. North Ave Oct 16/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 19 30

20 UNDERTAKER Geo. Brack Son 1906 Orleans

ADDRESS

pec.—1-30—M. & T.—250 Bks.

E 61345 ✓ E 61345

E 61345 HEALTH DEPARTMENT—CITY OF BALTIMORE 16-002

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Dabey

(a) RESIDENCE NO. 521 S Glover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Sept-21-1929

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1		22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Stephen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Krochesska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant

(Address) JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M. D., Registrar

41930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-13-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1930, to Oct 13, 1930, that I last saw h[illegible] alive on Oct 13, 1930, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Dysentery, Ac. Bacillary

(duration) 3½ weeks yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? exam of stools

(Signed) Mary Adams, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 19 19 30
20 UNDERTAKER	ADDRESS
Frank Brach & Son	1906 Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

E 61346

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 E 61346

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating

City of Baltimore: (No. Harbor Foot Broadway St. 2-4 Ward)

2-FULL NAME Calvin Jordon

(a) RESIDENCE NO. 712 423 N Richmond St Va Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown Jordon

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52 ~~18~~	unknown		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) unknown
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Richmond Va

PARENTS

10 NAME OF FATHER Thomas Jordon

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary O'Brien

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant Sallie B. O'Brien
(Address) 712 E 23 St

15 [illegible] 19 C. HAMPSON JONES, M. D. Registrar
4 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Accidental Drowning

Immediate
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ~~No~~ Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

Oct 13 1930 (Address) 7002 Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va. Oct 14 1930

DATE OF BURIAL

20 UNDERTAKER John C Miller

ADDRESS 2135 E Oliver

pec.—1-30—M. & T.—250 Bks

E 61347

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University of Maryland Hospital

CITY OF BALTIMORE: (No. ... ST. 4-30 ... WARD)

REGISTERED NO. ...
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Hunt

(a) RESIDENCE NO. ... Westminster, Md. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, ~~widowed~~, or divorced HUSBAND of (or) WIFE of Laura Ellen Hunt

DATE OF BIRTH (month, day, and year) ...

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of Industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

BIRTHPLACE (city or town) (State or country) Maryland Carroll Co.

10 NAME OF FATHER Charles F. Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laura E. Hunt
(Address) Westminster Md.

Filed ... 1930 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1930, to Oct 14, 1930,

that I last saw him alive on Oct 14, 1930,

and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach with
extension into liver

Exploring (duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical, X-ray, autopsy.

(Signed) C. E. Anders, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Chester, Md.,

DATE OF BURIAL Oct. 16 1930

20 UNDERTAKER Jacob Winkler Sons

ADDRESS Manchester Md.

Dec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61348

E 61348

CERTIFICATE OF DEATH Brooklyn 1-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 541 Maude Ave. 25-75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Norman E Williams

(a) RESIDENCE NO. 541 Maude Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 10 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Phern M Williams

DATE OF BIRTH (month, day, and year) Dec 3 1905

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	10	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crane Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Standard Chem. Co.

(c) Name of employer Curtis Bay

BIRTHPLACE (city or town) (State or country) Baltimore, Md

10 NAME OF FATHER Robert Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Catherine Lockington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

Informant Mrs Phern E Williams

(Address) 541 Maude Ave

C. HAMPSON JONES, M. D.

Registrar

Date 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12/1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1930, to Oct 12, 1930

that I last saw him alive on Oct 12, 1930

and that death occurred, on the date stated above, at 5 35 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) about 14 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No Answer

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) C Hampson, M. D.

, 19 (Address) 1215 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Oct 15 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St.

pec.—1-30—M. & T.—250 Blks.

E 61349

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61349

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH Church Home Infirmary

CITY OF BALTIMORE: (NO. North Broadway ST., 629 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Owens (1) Number One

(a) RESIDENCE NO. Church Home Infirmary ST., C 2 WARD Parkton, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Twenty six (26) minutes. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, hrs. or 26 min.
26 Minutes			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Donald Cort Owens

11 BIRTHPLACE OF FATHER (city or town) Idlewild
(State or country) Ark

12 MAIDEN NAME OF MOTHER Myrtle Ruth Johnston

13 BIRTHPLACE OF MOTHER (city or town) Idlewild
(State or country) Ark.

14 Informant Donald Cort Owens
(Address) Parkton, Maryland

15 Filed ... 19 ... HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1930, to Oct 13, 1930,

that I last saw her alive on 10-13, 1930,

and that death occurred, on the date stated above, at 12 42 P.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Davant Welder, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Home & Infirmary

DATE OF BURIAL OCT 14 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

For Wm. S. [illegible]

pec.—1-30—M. & T.—250 Bks.

E 61350 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61350

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH Church Home Infirmary

CITY OF BALTIMORE: (No. North Broadway ST., 629 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Ayers (2) Number Two

(a) RESIDENCE NO. Church Home Infirmary ST., C 2 WARD Parkton, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Twenty six (26) minutes How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Months	Days	If LESS than 1 day, ... hrs. or 26 min.
6 Minutes			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Ronald Earl Ayers

11 BIRTHPLACE OF FATHER (city or town) Talmid (State or country) N. C.

12 MAIDEN NAME OF MOTHER Myrtle Ruth Johnston

13 BIRTHPLACE OF MOTHER (city or town) Talmid (State or country) N. C.

Informant Ronald Earl Ayers
(Address) Parkton Md.

Filed OCT 4 1930, 19 C. HAMPSON JONES, M. D. Registrar

Ref. NCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13-30

17 I HEREBY CERTIFY, That I attended deceased from 10-13, 19 30, to 10-13, 19 30, that I last saw her alive on 10-13, 19 30, and that death occurred, on the date stated above, at 12:50 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Swartzbaugh, M. D.

19 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Home Infirmary

DATE OF BURIAL OCT 14 1930

ADDRESS

UNDERTAKER Commissioner of Health

WM. F. WOODS

1-30—M. & T.—100 B—50L

E 61351

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 61351

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) Baltimore City Hosp ST. 7-H WARD)

2-FULL NAME Veronica Morgan

(a) RESIDENCE NO 514 S. Ann ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60 ?				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs. Anischeck

(Address) 518 S Ann St

15 10-4 1930 C. HAMPSON JONES, M. D., Registrar

MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. A. Blake, M. D. Coroner

10/1 1930 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS OCT 14 1930

(Commissioner of Health)

Spec. 2-29-28—L. F. S.—500 Bks.

E 61352 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 E 61352

CERTIFICATE OF DEATH

28-63

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 3904 Ferndale Ave. ST. ..... (WARD) .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Henry Jackson

(a) RESIDENCE NO. 3904 Ferndale Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of (or) WIFE of Laura Virginia Jackson

DATE OF BIRTH (month, day, and year) Nov. 23, 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	10	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

10 NAME OF FATHER William Jackson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Cordelia Hitckcoch

13 BIRTHPLACE OF MOTHER (city or town) Harford County
(State or country) Maryland

Informant Mr. Samuel H. Jackson, Jr.

(Address) 3904 Ferndale Ave.

Filed 19 C. HAMPSON JONES, M. D.
Registrar

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1930, to Oct 13, 1930, that I last saw him alive on Oct 10, 19, and that death occurred, on the date stated above, at 8.35A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Observation

(Signed) C. C. Hamm, M. D.

Oct 14, 1930 (Address) 4509 Liberty Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Oct. 15 1930
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 West Baltimore St.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61353

CERTIFICATE OF DEATH

47 ✓ E 61353

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 N. Bentalou St. ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Roberta McFee Williams

(a) RESIDENCE NO. 1624 N. Bentalou St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Bryan Williams

DATE OF BIRTH (month, day, and year) Oct. 24, 1893

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	11	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER James H. McFee

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia R. Bowdle

13 BIRTHPLACE OF MOTHER (city or town) Oxford

(State or country) Maryland

Informant Mr. J. B. Williams

(Address) 1624 N. Benatlou St.

Filed 10/14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1929, to Oct. 13, 1930, that I last saw her alive on Oct. 12, 1930 and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of May 1929

Was there an autopsy? No

What test confirmed diagnosis? Path.

(Signed) Homer C. Wood, M. D.

10/13, 1930 (Address) 735 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

20 UNDERTAKER Joseph B Cook

DATE OF BURIAL Oct. 16 1930

ADDRESS 1003 West Baltimore St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61354

74-001 V

E 61354

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 608 Hanover St. 22-30 Ward)

2-FULL NAME Mollie B. Watson.

(a) RESIDENCE NO. 608 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced (or) WIFE of William H. Watson.

6 DATE OF BIRTH (month, day, and year) December 11, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	72	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Martinsburg, W. Va.
(State or country)

PARENTS

10 NAME OF FATHER John Bowers.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Martinsburg, W. Va.

12 MAIDEN NAME OF MOTHER Julia ---

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Martinsburg, W. Va.

14 Informant William H. Watson. (husband)
(Address) 608 Hanover St.

Oct 9 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14, 1930 '32

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.
Hemiplegia.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

10/14/1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg W Va — DATE OF BURIAL Oct 15 1930

20 UNDERTAKER George J Smith — ADDRESS 103 Hollins

Spec.—1-30—M. & T.—250 Bks.

E 61355

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61355

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Bristol Ave ST. 25-75 WARD)

2-FULL NAME Charles E. Lewis

(a) RESIDENCE NO. 8 Bristol Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3 If married, ~~widowed, or divorced~~ HUSBAND of ~~or] WIFE of~~ Elizabeth E. Lewis

DATE OF BIRTH (month, day, and year) Nov 2 1885

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	44	11	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER James T. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER Louisa Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Elizabeth E. Lewis

(Address) 8 Bristol ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

41930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14th 1930

17 I HEREBY CERTIFY, That I attended ~~deceased~~ deceased from Oct 12 " 1930 to Oct 14 " 1930,

that I last saw h~~e~~ alive on Oct 14 " 1930

and that death occurred, on the date stated above, at 12 45 ~~P~~ a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Heathcock M. D.

10/14, 1930 (Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 10/17/1930

UNDERTAKER Wm Cook

ADDRESS 1217 St Paul st

pec.—1-30—M. & T.—250 Bks.

E 61356 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61356

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 W. Mulberry ST., 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Likes

(a) RESIDENCE NO. 318 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If ~~married~~ widowed, ~~or divorced~~ HUSBAND of ~~or WIFE of~~ Jeanette

DATE OF BIRTH (month, day, and year) Aug 28th 1863

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	1	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stage Hand

(b) General nature of industry, business, or establishment in which employed (or employer) Theatrical

(c) Name of employer Maryland Theatre

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Jacob Likes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Catherine Spangler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Annie E. Likes

(Address) 1916 N. Monroe St

Filed ....., 19 .....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to October 13, 1930, that I last saw him alive on October 13, 1930, and that death occurred, on the date stated above, at 9.15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of the heart.

(duration) several yrs. — mos — da.

CONTRIBUTORY (Secondary) Acute decompensation

(duration) yrs. mos. 23 ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings.

(Signed) C. W. Fortenbaugh, M. D.

, 19 (Address) 8 Eastead St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 10/16/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

4 1930

pec.—1-30—M. & T.—250 Bks. Dr Freilinger Washington Blvd & Fremont St Plaza 6605

E 61357

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61357

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Burgundy St. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hahn

(a) RESIDENCE NO. 824 Burgundy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 15th 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	0	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

19 NAME OF FATHER John Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Buckrens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Charles Hahn

(Address) 824 Burgundy St

Filed 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1920, to Oct. 13, 1930, that I last saw h[illegible] alive on Oct 10, 1930, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) instantaneous

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) indefinite ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. K. Freilinger, M. D.

10/14 1930 (Address) 682 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn ~~Holy Redeemer~~ Cemetery

DATE OF BURIAL 10/16/1930

20 UNDERTAKER Wm Cook 1217 St Paul St

ADDRESS

pec.—1-30—M. & T.—250 Bks

61358

HEALTH DEPARTMENT—CITY OF BALTIMORE

61358

CERTIFICATE OF DEATH.

161-09

REGISTERED NO. E 61358

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1522 ST. 15-21 WARD)

2-FULL NAME Baby Girl Kirwan

(a) RESIDENCE NO. 1522 Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 hrs. 15 min. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct. 14, 1930

AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or 15 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Clinton Kirwan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Regina Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va.

Informant Mrs. Regina Kirwan

(Address) 1522 Monroe St.

C. HAMPSON JONES, M. D.

Filed Oct 4 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1930 to Oct. 14, 1930, that I last saw her alive on Oct. 14, 1930, and that death occurred, on the date stated above, at 4:35 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Clyde M Fauls, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgan Chapel, Woodlawn Md

DATE OF BURIAL Oct 15, 1930

20 UNDERTAKER Margaret L. Flynn

ADDRESS 1412 Light

Spec.—1-30—M. & T.—250 Bks.

E 61359

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61359

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 530 N. Bridle ST. 17-24 WARD)

2-FULL NAME Margaret Page Hailey

(a) RESIDENCE NO. 530 N. Bridle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) 1910

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	20			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Lewis Hailey

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Helen Parkins

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

Informant Helen Page, 530 N. Bridle St
(Address)

Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1930, to Oct 11, 1930, that I last saw her alive on Oct 11, 1930, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Ulcerative

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Sputum Exam

(Signed) Garland Grinnalds M. D.

(Address) 1534 Eutaw Pl Oct 13 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Sons

DATE OF BURIAL 10-14 1930

UNDERTAKER Dunn & Conroy

ADDRESS 916 Eutaw Pl

OCT 15 1930

30—M. & T.—100 B—50L

E 61360

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61360

CERTIFICATE OF DEATH

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. ST. (WARD) 17-24

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Holliday Henderson

(a) RESIDENCE NO 922 Wilmot St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Jerome Holliday

DATE OF BIRTH (month, day, and year) 1908

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	22			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Jerome Holliday

(Address) 922 Wilmot

Filed 51930 By G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH was as follows: (Accident)

24 3rd degree burns

Coal Stove (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Burned by stove Cooker (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 922 Wilmot

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Hirsh, M. D.

Oct. 14 (Address) Coroner

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-14 1930

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pine

Cor.—11-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61361

61361

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) University Hospital (Ward) 4-30

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula O'Dell Phelps

(a) RESIDENCE NO. 1310 L St., N.W. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced BUSBAND of (or) WIFE of Thomas Edward Phelps

6 DATE OF BIRTH (month, day, and year) May 28, 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	32	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Branch Goswellen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Ross

13 BIRTHPLACE OF MOTHER (city or town) Somerset County (State or country) Maryland

14 Informant Mr. Thos. Edward Phelps (Address) 1310 L St., N.W. Washington, D. C.

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

NOV 5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto in which she was riding collided with another machine

Ruptured Pancreas (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) H. Frame M. D.

(Coroner)

10/14 1930 (Address) 2939 N. Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Choptank, Caroline Co. Maryland Date of Burial Oct. 14 1930

20 UNDERTAKER Fred'k Cook ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 61362

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61362

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Alice Ann ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Madora Miller

(a) RESIDENCE NO. 2118 Alice Ann ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: George Miller

DATE OF BIRTH (month, day, and year): 1861

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

Informant: James L. Blizzard

(Address) 2118 Alice Ann St

OCT 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1930, to Oct. 13, 1930, that I last saw her alive on Oct. 13, 1930 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute gastritis

Chronic myocarditis

(duration) yrs. mos. (½) ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. W. Tilghman, M. D.

, 19 (Address) 431 S Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Oct. 15 1930

UNDERTAKER: Henry Sander & Sons - Inc.

ADDRESS: Baltimore St & Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

E 61363 E 61365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 16-73

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 E 23rd ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Maria Vogel Hilton St.; 10 yrs., mos. ds.)

(Residence in Baltimore: No. 604

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-~~SINGLE~~ MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) married

6-DATE OF BIRTH, Oct 16 (Month) (Day), 1874 (Year)

7-AGE 55 yrs. 11 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work housewife (b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Wick

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Marie Ackerman

13-BIRTHPLACE OF MOTHER (State or Country), America.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Charles W. Vogel

(Address) 604 Hilton

C. HERMON JONES, M.D.

15- OCT 15 1930

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 13 (Day) - 1930, 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1930, to Oct 13 1930, that I saw her alive on Oct 13 1930, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Encephalitis + Its Sequelae Lethargica + Coronary Thrombosis

(Duration) yrs. mos. 1 ds.

Encephalitis

CONTRIBUTORY (Secondary) Lethargica (Duration) yrs. 8 mos. ds.

(Signed) Nathaniel M. Beck M. D.

Oct 13, 1930 (Address) 1002 23rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 8 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Baltimore-604 Hilton

Former or usual residence Baltimore-604 Hilton

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 16, 1930,

20-UNDERTAKER Chas. Mrs. John W. Fayette & Son

ADDRESS 80 W. Fayette St

0—M. & T.—100 B—50L

61364 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 61364

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3913 Liberty Heights ST. 15-22 WARD)

2-FULL NAME Mary Joynor.

(a) RESIDENCE NO 1369 N. Stricker ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Comedon

DATE OF BIRTH (month, day, and year) 1890

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Willie Allen

Address 59-2104 N. Mowry

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) (duration) 2 yrs. ....mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Steele, M. D. (Coroner)

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Oct 15 1930

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pressman St

15 1930 SAMPSON JONES, M. D.

...sec.—1-30—M. & T.—250 Bks.

E 61365

E 61365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 v

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 651 W Mulberry ST., 425 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Stanmore

(a) RESIDENCE NO. 651 W Mulberry ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or WIFE of): George Stanmore

DATE OF BIRTH (month, day, and year): March 12, 1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	56	7	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Will Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Singleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

Informant: Lillian Stanmore

(Address)

Filed OCT 15 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 12. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 12, 1930, that I last saw her alive on Oct 12, 1930, and that death occurred, on the date stated above, at 9.0 P m.

The CAUSE OF DEATH* was as follows:

Hypertension
Chronic Myocarditis
Nephritis
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Cerebral Embolism
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? regular

(Signed) W. F. Howell M. D.

10/13/30 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Oct. 15, 1930

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N Schroeder St.

Cor.—10-10-29—A Co.—100 Bks.

E 61366

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61366

CERTIFICATE OF DEATH

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 254 Arlington Ave., 18-26 Ward)

2-FULL NAME John W. Taylor

(a) RESIDENCE NO. 254 Arlington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Taylor

6 DATE OF BIRTH (month, day, and year) May 30, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day Hrs. or min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Alfred Taylor

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Shepherd

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Ida Taylor
(Address) 254 Arlington Ave

C. HAMPSON JONES, M. D.
Registrar

OCT 15 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
Myocardial Insufficiency
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke M. D.

Oct 14 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL Oct 17, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 S. Schroeder St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61367 X 123 E 61367

CERTIFICATE OF DEATH.

REGISTERED NO.

1 PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave. St. 28-63 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lester Fidata Stumpenhagen

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE 54 Years — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister of Christian Charity

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Franz Stumpenhagen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Fuest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mt. Hope Retreat Baltimore Md.

15 10 5 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14 1930

17 I HEREBY CERTIFY, That I attended deceased from August, 1930, to Oct 14, 1930, that I last saw her alive on 10-14, 1930, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 2 mos ds.

Uremia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hjalmar S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross aa Co DATE OF BURIAL 10-16 1930

20 UNDERTAKER E H B Hall 115 E North Ave ADDRESS

ec.—1-30—M. & T.—250 Bks.

E 61368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 61368

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hosp

CITY OF BALTIMORE: (No. ... ST. 9-46 ... WARD)

2-FULL NAME James Worthington

(a) RESIDENCE NO. 711 East 22 St. ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed or divorced HUSBAND of or) WIFE of Elizabeth Worthington

DATE OF BIRTH (month, day, and year) Aug 14 1851

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	2	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Wm. Worthington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Elizabeth Worthington

(Address) 711 E 22nd St

Filed OCT 5 1930, 19 ... C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 15 30

17 I HEREBY CERTIFY, That I attended deceased from 10 13, 19 30, to 10-15, 19 30

that I last saw h[illegible] alive on 10-14, 19 30

and that death occurred, on the date stated above, at 12 50 PM

The CAUSE OF DEATH* was as follows:

Neoplasm Splenic flexure with

Intestinal obstruction

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 10-1930

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) W. A. Lindsay M. D.

, 19 (Address) 22 W Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Townsend

UNDERTAKER Eagle Hill Cem.

DATE OF BURIAL 10-17 19 30

ADDRESS Havre de Grace Md.

pec.—1-30—M. & T.—250 Bks

E 61369 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61369

CERTIFICATE OF DEATH.

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 905 (Street) Eastern ave (WARD) 2-5

2-FULL NAME Joseph Charles Wolfe

(a) RESIDENCE NO. 905 (Usual place of abode) Eastern ave WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

6 If married, widowed, or divorced HUSBAND of or) WIFE of Infant

DATE OF BIRTH (month, day, and year) Sept. 3. 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Claude H. Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lauterburg Maryland

Informant Claude H. Wolfe

(Address) 905 E. Eastern ave

Filed OCT 15 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Octob 15 30

17 I HEREBY CERTIFY, That I attended deceased from Octob 5, 1930, to Octob 14, 1930, that I last saw ~~him~~ alive on Octob 14, 1930, and that death occurred, on the date stated above, at 1.00 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Nephritis

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Presumably

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Joseph L. Valentine M. D.

Oct 15, 19 30 (Address) 1450 Brosby

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Oct 15 19 30

20 UNDERTAKER Wendell & Hupp — ADDRESS 300 N Caroline

pec.—1-30—M. & T.—250 Bks

E 61370

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 61370

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Mercy Hosp. ST. 27-43 (WARD)

2-FULL NAME George A Tanner.

(a) RESIDENCE NO. 3118 Clearview Ave ST., WARD A (Col.)
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

If married, widowed, or divorced
HUSBAND of
or) WIFE of Mrs. Doris Tanner.

DATE OF BIRTH (month, day, and year) Jan 14. 1894

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~Jan~~	36	~~Jan~~ 9.	1	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Claim Adjuster for Oil
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Cleveland. Ohio
(State or country)

10 NAME OF FATHER Ella Tanner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Anna Sperry.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio.

Informant Hospital Records.
(Address)

Filed OCT 15 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15/30

17
I HEREBY CERTIFY, That I attended deceased from
10/13/30, 19 ..... to 10/15/30, 19 .....,
that I last saw him alive on 10/14/30, 19 .....,
and that death occurred, on the date stated above, at 1.30 A.M. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

6 Days. (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J Lyko., M. D.
, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cleveland Ohio
DATE OF BURIAL Oct 16 1930.
20 UNDERTAKER Walter R. McNamee
ADDRESS 4045 Fairmount Blvd.

Spec.—1-30—M. & T.—250 Bks.

E 61371

E 61371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 E. 23rd St. 17-50 WARD)

2-FULL NAME Bettie Pugh

(a) RESIDENCE NO. 306 E. 23rd St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of George Pugh

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant John Plummer

(Address) 306 E. 23rd St.

Filed JAN 15 1930, 19..

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1930, to Dec 13, 1930, that I last saw her alive on Dec 13, 1930, and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexy

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) L. H. Wall, M. D.

, 19 (Address) 1826 23 d Parkwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md

DATE OF BURIAL Dec 15, 1930

20 UNDERTAKER Mrs. W. G. Elliott

ADDRESS 1705 Gardenia Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 61372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 61372

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. German Aged Home ST. 20-37 WARD)

2—FULL NAME Catherine Samstag

(a) RESIDENCE NO. German Aged Home Baltimore and Payson STS WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) February 2, 1849

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	8	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER George Pracht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helen Herring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant German Aged Home
(Address) Baltimore and Payson Sts.

Filed 5 1930 C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st 1930 to Oct 13th 1930
that I last saw her alive on Oct 13th 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Arteriosclerosis —

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical —

(Signed) Stiles Hemming M. D.
10/15 1930 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Oct. 16 1930

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St.

0—M. & T.—100 B—50L

E 61373

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61373

185

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 605 N. Paca ST. 17-25 (WARD)

2-FULL NAME John Taylor

(a) RESIDENCE NO. 605 N. Paca ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Clementine

DATE OF BIRTH (month, day, and year): 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): O'S
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant: Rosie Taylor

(Address) 222 S. Spring St.

Filed ..... 1930 CHAMPION JOHNS, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct 12th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
Fractured Skull
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Fell down steps
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 605 N. Paca

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Klunk, M. D.

Oct 13 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: Oct 15 1930

20 UNDERTAKER: Chas. H. Johnson — ADDRESS: 416 N. Carlton St

pec.—1-30—M. & T.—250 Bks

E 61374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-802 E 61374

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 22-30 WARD)

2-FULL NAME Luther Johnson

(a) RESIDENCE NO. 521 Linden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) 1891

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Geo Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nellie Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Mrs Johnson

(Address) 521 N Linden St

Filed 5 1930 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1930, to Oct 12, 1930, that I last saw him alive on Oct 12, 1930, and that death occurred, on the date stated above, at 9:35 Am.

The CAUSE OF DEATH* was as follows:

Vincent's Angina

(duration) — yrs. — mos 24 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings and autopsy

(Signed) Eugene A. Kraus, Jr. M. D.

10-12 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnson Farm	Oct 16 1930
20 UNDERTAKER	ADDRESS
Joseph A Lesch	1032 Wood St

pec.—1-30—M. & T.—250 Bks.

E 61375 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 61375

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Low St. ST. 5-8 (WARD)

2-FULL NAME Dominick Pessagno

(a) RESIDENCE NO. 905 Low St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Widower

6 If married, widowed, or divorced HUSBAND of or) WIFE of Flamena Pessagno.

DATE OF BIRTH (month, day, and year) Aug. 23rd/1846

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	1	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Candy Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Antonio Pessagno

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Domanic Pessagno Jr.
(Address) 905 Low St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14th. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1- 1930, to Oct 14 1930, that I last saw him alive on Oct. 13 1930, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Disease, [redacted]
(Acute) (Aortic + Mitral Insufficiency)
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Arterio sclerosis
(duration) 1+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) A. A. Pinto, M. D.

10/14 1930 (Address) 1117 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery.

DATE OF BURIAL 10/16 1930

20 UNDERTAKER Chas. F. Grace & Son ADDRESS 1181 Mt Royal ave

5 1930

pec.—1-12-23—M&T—500 Blks.

E 61376 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61376

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 W. Cross, ST. 21-24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary R. Kinsey

(a) RESIDENCE NO. 1137 W. Cross ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: ..... Kinsey

6 DATE OF BIRTH (month, day, and year): Nov 27 1853

7 AGE: Years 76 Months 11 Days 17 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Wm Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs E. Griffin

(Address): 1137 W Cross St

15 [illegible] 1930 G. HAMPSON JONES, M. D. Registrar

406

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Oct 17, 1930, that I last saw h[illegible] alive on Oct 13, 1930, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Maury Hoag, M. D.

10/18, 1930 (Address) 729 Linden Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 10/16/30 19

20 UNDERTAKER: Geo Lumbach & Son

ADDRESS: Lyndhurst

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61377

E 61377

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1335 W. Lombard St. 18-29 Ward)

2-FULL NAME Theresa Schloss

(a) RESIDENCE NO. 1335 W. Lombard St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	About 65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER — Schloss

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Mr. N. Schloss
(Address) Balto. & Paca Sts.

15 Filed 5 1930 19 C. HAMPSON JONES, Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. S. Brooke, M. D.

10/15 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 10/16 1930

20 UNDERTAKER Harris Sondheimer

ADDRESS 1701 Eutaw Place

pec.—1-30—M. & T.—250 Bks.

241024
E 67378

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 67378

113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-1 WARD)

2-FULL NAME Virginia Estremski

(a) RESIDENCE NO. 1005 So. Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced, (write the word)~~
Female	White	Child

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 2, 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Stanley Estremski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Date OCT 15 1930, 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1930, to Oct. 14, 1930, that I last saw her alive on Oct. 14, 1930, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Entritis & Diarrhoea

4 weeks.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) L. C. Goodwin, M. D.

10/14 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus cem DATE OF BURIAL Oct 17 1930

20 UNDERTAKER John M Weber ADDRESS 401 S. Chester

pec.—1-30—M. & T.—250 Bks.

61379

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61379

CERTIFICATE OF DEATH.

51

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2110 Hollins ST. 20-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Kershaw.

(a) RESIDENCE NO. 2110 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of Edwin G. Kershaw.

DATE OF BIRTH (month, day, and year) Feb 28/1850.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80.	7.	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs Ann L. Gray. (Address) 2110 Hollins St

File 51930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14/30.

17 I HEREBY CERTIFY, That I attended deceased from 10/2 , 1930, to 10/14 , 1930, that I last saw h.. alive on 10/14 , 1930, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis Hypertension

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary

(Signed) Chas A Cahn, M. D.

10/15 1930 (Address) 2145 N Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cem Hampden — DATE OF BURIAL Oct 17 1930

20 UNDERTAKER Horace F Burgess — ADDRESS 3631 Falls Rd.

pec.—1-30—M. & T.—250 Bks.

E 61380 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61380

100 001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 509 St Paul ST. 12-19 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie C. Wheeler

(a) RESIDENCE NO. 509 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Jan 17 1864

AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	66	8	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Chas E. Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Lillie C. Wheeler

(Address) 509 St Paul

Filed Oct 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10" 1930, to Oct. 15 1930,

that I last saw h[illegible] alive on Oct. 14 1930,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Marked exhaustion - Emaciation - 50 lbs below normal weight - 2 mos. to 4 yrs.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Typical symptoms

(Signed) A. F. Robinson, M. D.

10/15 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Oct 16 1930

20 UNDERTAKER H. M. Cook — ADDRESS 1217 St Paul

pec.—1-30—M. & T.—250 Blks.

E 61381 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61381

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U S MARINE HOSPITAL

CITY OF BALTIMORE: (No. Baltimore, Md. St. 12-51 WARD)

2-FULL NAME Ellis J. Hill

(a) RESIDENCE NO. 118 E. Bodily St., Stl Louis, Mo. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) February 3, 1904

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	8	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Express

BIRTHPLACE (city or town) Carthage (State or country) Missouri

10 NAME OF FATHER John Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Emma Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 Informant Records, U.S. Marine Hospital (Address) Baltimore, Md.

15 1930 16 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from September 26, 19 30, to October 15, 19 30,

that I last saw him alive on October 15, 19 30,

and that death occurred, on the date stated above, at 11:05 A.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos 27 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) Gordon A. Abbott, M. D.

10/15, 30 (Address) US Marine Hospital, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Vincennes, Indiana

DATE OF BURIAL Oct. 15, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc.

ADDRESS 125 E. North ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61382

169 E 61382

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Waxters Ice Pond St. 1428 Ward)

2-FULL NAME Elizabeth Bartell

(a) RESIDENCE NO. 209 S. Vincent St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick J. Bartell

6 DATE OF BIRTH (month, day, and year) May 7 - 1860.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work N. W 037
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Anna Berger

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Wm E Fowler
(Address) 209 S. Vincent

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

OCT 16 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide - By drowning in Waxters Ice Pond 2200 Block Annapolis Ave

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Charles A Mencke, M. D.

Oct 14 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westview Cemetery	Oct. 16 1930
20 UNDERTAKER J. B. Hilgert Jr.	ADDRESS 1853 W. Baltimore

ec.—2-29-28—L. F. S.—500 Bks.

E 61383

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61383

CERTIFICATE OF DEATH

14-001

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

ITY OF BALTIMORE: (No. 19-26 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Emily Porter

(a) RESIDENCE NO. 317 N. Fulhouse ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

ength of residence in city or town where death occurred 40 yrs. mos. ds. — How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Porter

DATE OF BIRTH (month, day, and year) May 30th 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 87

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Illinois

10 NAME OF FATHER Cornelius Stuntons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Elsie Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Frank L. Coates

(Address) 25 W. Lanvale St

Received OCT 16 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15/30

17 I HEREBY CERTIFY, That I attended deceased from 10-14, 1930, to 10-15, 1930, that I last saw h er alive on 10-15-30, 19, and that death occurred, on the date stated above, at 5 30 m.

The CAUSE OF DEATH* was as follows:

Hypertension

Cerebral Hemorrhage

(doration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) C. W. Peare, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Loudon Park Cemetery

DATE OF BURIAL Oct 17 30

UNDERTAKER — C. B. Wippert

ADDRESS 1853 W. Baltimore St

pec.—1-30—M. & T.—250 Bks.

E 61384

E 61384

HEALTH DEPARTMENT—CITY OF BALTIMORE

74001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 W. Lafayette St., Ward 22)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine A. Cullison

(a) RESIDENCE NO. 1919 W. Lafayette St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Wm. F. Cullison

DATE OF BIRTH (month, day, and year) Nov 28, 87

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	6	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Adolph Uhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. F. Cullison

(Address) 1919 W. Lafayette St.

15 Filed OCT 16 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 30, 1930, to date of death Oct 13/30

that I last saw h.. alive on Oct 13 30 10 a m.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ven b basilar hemorrhage

(Apoplexy) Sudden

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension, arteriosclerosis

duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Pinkney Lee Sands, M. D.

, 19 (Address) 127 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interstate Cemetery

DATE OF BURIAL Oct 16 1930

UNDERTAKER H. S. Kilpatrick

ADDRESS 1050 W. Baltimore St

Rec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 61385

E 61385

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 Linden Ave. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Vankin

(a) RESIDENCE NO. 1525 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Vankin

DATE OF BIRTH (month, day, and year)

AGE: Years 71; Months; Days; If LESS than 1 day, hrs. or mio.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: L. Lewis

(Address): 1439 Eback St

Filed ..... 19..... HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-15-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 19 30, to same, 19 .

that I last saw him alive on Oct. 15, 19 30.

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) Nathan Shnitz, M. D.

19 (Address) 2318 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lehmus Funeral

20 UNDERTAKER: Asp Heirs. 1439

DATE OF BURIAL: 10-16-1930

ADDRESS: Eback St.

pec.—1-30—M. & T.—250 Bks.

E 61386

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 15-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FREIDA Rachael Silverman

(a) RESIDENCE NO. 3526 W. Garrison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of Moses Silverman

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 Eutaw St

15 Filed 1930 G. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/30

17 I HEREBY CERTIFY, That I attended deceased from 6/30, 1930, to 10/14, 1930, that I last saw he~~r~~ alive on 10/14, 1930, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & X-Ray

(Signed) Burgess Klotz, M. D.

, 19 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Northern Ave.

DATE OF BURIAL 10-16-19 30

UNDERTAKER Jack Lewis, 1439 E Baltimore St.

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Blks.

E 61387

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61387

101-001

CERTIFICATE OF DEATH.

Registered No. 28 63

1-PLACE OF DEATH

City of BALTIMORE: (No.) 4008 Groveland Ave St., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Ripsman

(a) Residence No. 4008 Groveland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Rose Colvin

6-DATE OF BIRTH (month, day and year): 7-29-1875

7-AGE: 55 yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Shirt business

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS

10-NAME OF FATHER: Nathaniel Ripsman

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Colvin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14- (Informant) Arthur Ripsman

(Address) 4008 Groveland Ave

15- Filed OCT 16 1930 G. HAMPSON JONES, M. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 10/15/1930

17- I HEREBY CERTIFY, That I attended deceased from Oct. 11th 1930 to Oct. 15th 1930

that I last saw him alive on Oct. 15th 1930

and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

about 9 ds.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Clot.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis: Physical

(Signed) L. Thurlow M. D.

, 19 (Address) 2122 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Fairview Memory Gardens — DATE OF BURIAL: 10-16-, 19 30

20-UNDERTAKER: Rose Davis — ADDRESS: 1131 Eden St.

I-30—M. & T.—100 B—50L

E 61388

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61388

CERTIFICATE OF DEATH

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ~~Sinai Hospital~~ ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Weiner

(a) RESIDENCE NO 2316 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Nathan Weimer

6 DATE OF BIRTH (month, day, and year) Sept 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Kuft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Leah Goldberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto. St

15 Filed ..... 192 C. HAMPSON JONES, Registrar

OCT 15 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis
Chr. Myocarditis
Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Course

(Signed) [illegible], M. D. Coroner

Oct 17/30 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Sinai Cemetery

DATE OF BURIAL 10-16-1930

20 UNDERTAKER [illegible]

ADDRESS [illegible]

Spec.—1-30—M. & T.—250 Bks

61389 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61389

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5945 Kevon Ave. ST. 26-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANK B. DORMAN

(a) RESIDENCE NO. 5945 Kevon Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia G. Dorman

DATE OF BIRTH (month, day, and year) October 1, 1853

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77		13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker 014

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 8 years

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Frank Dorman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Amelia G. Dorman

(Address) 5945 Kevon Ave. C. WATSON JONES, M. D.

Filed Oct 16 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1930, to Oct 14th, 1930, that I last saw her alive on Oct 14th, 1930, and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Uremia Poisoning

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Coma (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. H. Lemmon M. D.

Oct 17, 1930 (Address) 4900 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Immanuel Cemetery

UNDERTAKER

Frederick Lanahan Son

DATE OF BURIAL

Oct. 17, 1930

ADDRESS

7401 Belair Rd.

Spec.—1-30—M. & T.—250 Bks

E 61390

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61390

CERTIFICATE OF DEATH.

REGISTERED NO. 70 26-42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4909 E. Hamilton Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ALBERT M. BECKMAN

(a) RESIDENCE NO. 4909 E. Hamilton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Beckman

DATE OF BIRTH (month, day, and year) August 24, 1872.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

10 NAME OF FATHER John Beckman

11 BIRTHPLACE OF FATHER (city or town) Hanover (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Buttner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eva Beckman

(Address) 4909 E. Hamilton Ave.

15 Filed 1-6 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Oct. 14, 1930,

that I last saw him alive on Oct. 14, 1930,

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. 3 mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pearsons, M. D.

10.15.1930 (Address) 5.14 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Oct. 18 1930

20 UNDERTAKER Frederick Lansdale Inc

ADDRESS 7401 Belair Rd.

pec.—1-30—M. & T.—250 Bks.

E 61391

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61391

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 13-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD .....

2-FULL NAME William F Wahler

(a) RESIDENCE NO. 2230 Ruskin Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Bertha L. Wahler

DATE OF BIRTH (month, day, and year) July 6, 1853

AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
77	77	3	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER William L Wahler

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elise Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Living Son (Daughter)

(Address) 2230 Ruskin Ave

Filed 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1930, to Oct 14, 1930, that I last saw h.. alive on Oct 14, 1930, and that death occurred, on the date stated above, at 10.25 Am.

The CAUSE OF DEATH* was as follows:

Benign prostatic hypertrophy.

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) yrs. 6 mos ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? Yes Date of Aug 6, 1930

Was there an autopsy? No

What test confirmed diagnosis? Phys Exam

(Signed) Samuel McLanahan, M. D.

Oct 14, 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Oct. 16, 30

20 UNDERTAKER Wm J Tickner Sons ADDRESS North Pa

Spec.—1-30—M. & T.—250 Bks

E 61392 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61392

113v

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1609 Olive ST. 23-32 (WARD)

2-FULL NAME Betty Lou Miller

(a) RESIDENCE NO. 1609 Olive ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 25-1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Theodore A. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis

12 MAIDEN NAME OF MOTHER Lillie A. Appel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

Informant Lillie A. Miller

(Address) 1609 Olive St.

Filed 10/18/30 C. HAMPSON JONES, M. D. Registrar

16

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Oct 14, 1930,

that I last saw her alive on 10-14, 1930,

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) M. L. Lichtenberg, M. D.

10/18/1930 (Address) 1 W Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Oct 16 1930

20 UNDERTAKER Margaret E. Flynn — ADDRESS 1422 Eutaw St.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61393

CERTIFICATE OF DEATH

129

E 61393

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 E. ~~Fort~~ Jordan ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Schafer

(a) RESIDENCE NO. 1513 E ~~Fort~~ Jordan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward J Schafer

DATE OF BIRTH (month, day, and year) June 11 - 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) New York N.Y.

10 NAME OF FATHER ? Kaa.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant Mary Schafer Daughter

(Address) 1513 E Jordan

C. HAMPSON JONES, M. D.

Filed , 19 Registrar

OCT 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14-30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1930, to October 14, 1930, that I last saw h alive on Oct 13, 1930 and that death occurred, on the date stated above, at 8 05 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Uraemia

(Signed) Thos. J. a. Stevens, M. D.

10/14, 1930 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A. A. Co.

DATE OF BURIAL Oct. 17 1930

20 UNDERTAKER Margaret E. Thomas

ADDRESS 1422 Light St.

Spec.—1-30—M. & T.—250 Bks

E 61394

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61394

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 417 Sanders ST. 24-35 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna I. Meyers

(a) RESIDENCE NO. 417 Sanders ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) July 16-191X

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18	2	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Herman C. Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pula. Pa

12 MAIDEN NAME OF MOTHER Mary Benton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

Informant Mary Meyers

(Address) 417 Sanders St.

Filed OCT 16 1930, 19

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1930, to Oct. 14, 1930,

that I last saw HER alive on Oct. 14, 1930,

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 3 yrs. mos da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) H. C. Campbell, M. D.

10/15 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Oct 18-1930

20 UNDERTAKER Margaret E. Flynn

ADDRESS 1422 Light St

Spec. 12-23-21—E.B.R.S.—400 Bks.

E 61395

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61395

CERTIFICATE OF DEATH.

114 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 161 N. Curley St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Brown King

(a) Residence No. 161 N. Curley St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write this word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John T. King

6-DATE OF BIRTH (month, day and year)

7-AGE 92 ? yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) City

PARENTS

10-NAME OF FATHER, Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Connecticut

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

14- (Informant) Jno T. King

(Address) 161 N. Curley St

15- Filed OCT 16 1930 (SIGNATURE OF Registrar)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 14/30.

17- I HEREBY CERTIFY, That I attended deceased from Oct 11, 1930 to Oct 14, 1930 that I last saw h. alive on Oct 14, 1930, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis old age.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Meyer Jr M. D.

10/14, 1930 (Address) 1500 E. 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel DATE OF BURIAL, Oct. 16 1930

20-UNDERTAKER John A Moran ADDRESS 3000 E. Balto St

Spec.—1-10-21—M&T—1500 Bks.

E 61396 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 61396

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1441 Mount St. 15-21 WARD)

2-FULL NAME Laura Hawkins

(a) RESIDENCE NO. 1441 Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louis Hawkins

6 DATE OF BIRTH (month, day, and year) June 18 1877

7 AGE: Years 41 | Months 4 | Days 6 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jerre Perew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Perew

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Laura Hawkins

(Address) 1441 Mount St

15 Filed 1935 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1930, to Oct 14, 1930,

that I last saw h- alive on Oct 14, 1930,

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

Oct 17, 1930 (Address) 1728 Pinna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery

DATE OF BURIAL: Oct 17 1930

20 UNDERTAKER: Thomas E. Kelson

ADDRESS 1303 Presstman St

Spec.—1-30—M. & T.—250 Bks

E 61397 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61397

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1717 N. Appleton ST. 15-21 (WARD)

2-FULL NAME Alice Millison

(a) RESIDENCE NO. 1717 N. Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry Millison

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

Informant Jack Lewis

(Address) 1439 E. Baltimore St.

Filed Oct. 19 HAMPSON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1930, to Oct 13, 1930,

that I last saw her alive on Oct 13, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein, M. D.

10/15, 1930 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted]

DATE OF BURIAL 10-16, 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto St

Spec.—1-30—M. & T.—250 Bks.

E 61398

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-007 E 61398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH The Church Home & Infirmary

CITY OF BALTIMORE: (No. N. Broadway ST., 8-17 WARD)

2-FULL NAME Mrs. Henrietta Arnold

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2035 E. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Charles F. Arnold

DATE OF BIRTH (month, day, and year): Sept. 29 1868

AGE: 62 Years; Months; 15 Days; If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto.

10 NAME OF FATHER: John Kroeme

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Ger~~ Penn.

12 MAIDEN NAME OF MOTHER: Marg. Dix

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

Informant: Mr. Chas. F. Arnold

(Address) 2035 E. Biddle St.

Filed 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14, 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to October 14, 1930, that I last saw h~~e~~s alive on October 14, 1930, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Biliary Peritonitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Paralytic ileus

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 3, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? History - Physical Findings Autopsy

(Signed) J. Frank Hewitt, M. D.

Oct 14. 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Oct. 18 1930

20 UNDERTAKER: Jos. J. Herr

ADDRESS: 156 N. Luzerne ave.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61399 90 E 61399

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 21-29 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate McCarthy

(a) RESIDENCE NO. 1122 Burgunder Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Michael Cannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Records of Balto. City Hosp.

(Address) ~~Baltimore, Md.~~

Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13-30

17 I HEREBY CERTIFY, That I attended deceased from 3-8-30, 19..., to 10-13-30, 19...,

that I last saw her alive on 10-13-30, 19...,

and that death occurred, on the date stated above, at 2:15 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) more than 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home & Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

10-15-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL Oct 16 1930

20 UNDERTAKER John J. Fahey Sons

ADDRESS 1318 Light St

Rev. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61400

CERTIFICATE OF DEATH

31 E 61400

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 1108 w. Saratoga St. 18-7a WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Raymond. M. Ehrman

(a) RESIDENCE NO. 1108 w. Saratoga ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 9 mos. 17 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced,~~ (write the word)
Male	white	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian. M. Ehrman

DATE OF BIRTH (month, day, and year) June 1 1894

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	9	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore MD

10 NAME OF FATHER Charles A Ehrman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore MD

12 MAIDEN NAME OF MOTHER Virginia Hyte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore MD

Informant Lillian. M. Ehrman

(Address) 1108 w. Saratoga

Filed 1930, 19 HAMPTON JONES, Registrar M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1930, to October 12 1930, that I last saw h~~im~~ alive on October 12, 1930 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Subacute Diffuse Nephritis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Edmonton

(Signed) Grant Lloyd, M. D.

Oct 15, 1930 (Address) 2005 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL Oct 17 1930

20 UNDERTAKER Jos. Joerdens & Son

ADDRESS 2173 E. ~~Fayette~~ Monument

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61401

CERTIFICATE OF DEATH.

10-001 E 61401

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 20-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Arnold, Jr.

(a) RESIDENCE NO. 2745 Wilkens Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 4, 1923

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	7	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER John J. Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Emma Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

Informant Mrs. Emma Arnold

(Address) 2745 Wilkens Av.

Filed 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1930, to Oct 16, 1930, that I last saw him alive on Oct 16, 1930, and that death occurred, on the date stated above, at 3 50 A.m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Throat Culture

(Signed) L. Peter Menasaki, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Oct 16 1930.

UNDERTAKER W. H. Nugent ADDRESS 1153 W. Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 61402 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 61402

CERTIFICATE OF DEATH

REGISTERED NO. 15-61

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3601 Fairview ave ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac Caplon

(a) RESIDENCE NO. 3601 Fairview ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mollie

DATE OF BIRTH (month, day, and year) 1868

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Kadish Caplon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs A. Caplon

(Address) 3601 Fairview ave

Filed OCT 16 1930 H. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15/30

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Oct 15, 1930, that I last saw him alive on Oct 15, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; ~~heart~~ disease Chr. Myocarditis Cardiac dilatation - duration 3 yrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Meyer Miller, M. D.

10/15, 1930 (Address) 3649 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave — DATE OF BURIAL Oct 16, 1930

20 UNDERTAKER Kirnon & Bro — ADDRESS 1127 E Balto st

Spec.—1-10-21—M&T—1500 Bks.

Litchfield

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61403

E 61403

CERTIFICATE OF DEATH.

129 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 E. Federal ST. 8-17 WARD)

2-FULL NAME Louis M. Litchfield

(a) RESIDENCE NO. 1507 E Federal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Litchfield

6 DATE OF BIRTH (month, day, and year): Dec 22 1846

7 AGE: 84 Years, Months 1, Days 9 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa.

PARENTS

10 NAME OF FATHER: John Rolland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't know

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't know

14 Informant: William Litchfield
(Address) 1507 E Federal St

15 Filed 6 1930 C. HAMPSON JONES, M. D., Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to Oct 15, 1930, that I last saw her alive on Oct 15, 1930, and that death occurred, on the date stated above, at 9 a m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wahne T Owens, M. D.

, 19 (Address) 1003 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 18 1930

20 UNDERTAKER: Josiah Lyser — ADDRESS: 1000 W North Ave

Spec.—1-30—M. & T.—250 Bks.

9415-32
E 61404

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61404

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Jones

(a) RESIDENCE NO. 116 N. Medeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Julia

DATE OF BIRTH (month, day, and year) May 27 1869

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

BIRTHPLACE (city or town) (State or country) La —

10 NAME OF FATHER Andrew Jones

11 BIRTHPLACE OF FATHER (city or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER Mary Wells

13 BIRTHPLACE OF MOTHER (city or town) Md —

(State or country)

Informant Reeds —

(Address) JOHNS HOPKINS HOSPITAL

Filed OCT 16 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13-30

17 I HEREBY CERTIFY, That I attended deceased from Oct-10, 1930, to Oct-13, 1930, that I last saw h[illegible] alive on Oct-13, 1930, and that death occurred, on the date stated above, at 12 10 p m.

The CAUSE OF DEATH* was as follows:

intestinal obstruction

Hypertension; chronic nephritis

incidents (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at work

Did an operation precede death? yes Date of 10-12-30

Was there an autopsy? yes - partial

What test confirmed diagnosis? operation

(Signed) J A Abercrombie, M. D.

, 19 (Address) J H H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL 10-16 1930

20 UNDERTAKER Byron Wright 1218 McElderry St

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E. Hall
15:00 E North

E 61405

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61405

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1309 E North Ave ST. 9-18 WARD)

2-FULL NAME William H Rochester

(a) RESIDENCE NO. 1309 E North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Fredricka M Rochester

DATE OF BIRTH (month, day, and year) Oct 21, 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	11	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER William Rochester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ~~Sarah Jones~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs M Rochester

(Address) 1309 E North Ave

Filed OCT 16 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15, 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 3, 1930, to Oct 15, 1930,

that I last saw him alive on Oct 14, 1930,

and that death occurred, on the date stated above, at 3-11 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. Gill Hall, M. D.

Oct 15, 1930 (Address) 1631 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	10/17 1930
UNDERTAKER William Cook	ADDRESS 1217 E Fayette St

Spec.—1-30—M. & T.—250 Bks.

Dr Bode 1900 Md Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61406

E 61406

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 616 Springfield Ave ST. ..... WARD) Ore 47

2-FULL NAME William R. V. Hipsley

(a) RESIDENCE No. 616 Springfield Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of Emma Catherine Hipsley

DATE OF BIRTH (month, day, and year) Oct 15, 1842

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Custom Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) U S Govt

(c) Name of employer U S Govt

BIRTHPLACE (city or town) (State or country) Balto Co. Md

10 NAME OF FATHER Henry Hipsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret E Gent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Emma C Hipsley
(Address) 616 Springfield Ave

15 Filed OCT 16 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 25, 1930, to October 14, 1930,

that I last saw him alive on Oct 14, 1930,

and that death occurred, on the date stated above, at 5.45 A.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) ..... yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loud Ridge	10/17 1930
20 UNDERTAKER Wilson Cook	ADDRESS 1212 Broad St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61407

90 E 61407

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE, (No. 612 S. Bethel St. 2-4 Ward)

2-FULL NAME Rudolf (Rudolph) Blazek

(a) RESIDENCE NO. 612 S. Bethel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 22 1861

7 AGE — Years: 69 — Months: 6 — Days: ~~7~~ 20 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Czecho-Slovakia

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Czecho Slovakia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Czecho-Slovakia

14 Informant (Address) Joseph Blazek 612 S. Bethel St.

15 1930 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 15 Oct 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Hanlon M. D. (Coroner)

10 16 1930 (Address) 7002 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — Date of Burial: Oct. 18 1930

20 UNDERTAKER: Stephen J. Fialkowski — ADDRESS: 1000 S. Kenwood ave

Spec.—1-30—M. & T.—250 Bks

E 61408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 61408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 609 Glenwood ave. ST. 27-48 WARD

2-FULL NAME Michael J. Griffin

(a) RESIDENCE No. 609 Glenwood ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Kath. Jimmerman Griffin

DATE OF BIRTH (month, day, and year) Dec. 14 1873

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett & Hayward Co

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Paul Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kath. D. Dilhoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant (Address) Thos. Glenwood ave 609 Glenwood ave

Filed 1930 G. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1930, to Oct 14, 1930,

that I last saw him alive on Oct 14, 1930,

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis — High Blood Pressure

Chr Ent. Nephritis

Chr Myocarditis

(duration) 2+ yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 1100 Lyon St - Auto Bus

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. V. Bishop, M. D.

Oct 15, 1930 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newbath cemetery — DATE OF BURIAL Oct. 18 1930

20 UNDERTAKER J. A. Moran — ADDRESS 3000 E. Baltimore

0—M. & T.—200 B—50L

E 61409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1409 E 61409

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

2-FULL NAME Unknown Unknown

(a) RESIDENCE NO ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: Negro | 5 Single, Married, Widowed, or Divorced (write the word):

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50?			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Unknown

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant .....

(Address) .....

Filed ..... 193 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D. Coroner

Oct. 1, 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: OCT 16 1930

20 UNDERTAKER: Commissioner Health.

ADDRESS

HAMPSON JONES

P.S.—Wm. F. WOOSALL

Spec. 1-16-29—La F. & P. 100 Bks.

E 61410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 E 61410

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4501 Roland Avenue ST., 17-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William T. Scott

(a) RESIDENCE NO. 4501 Roland Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Sherer

DATE OF BIRTH (month, day, and year) April 9, 1840

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	6	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Not obtainable

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

Informant T. Quincy Scott

(Address) 4501 Roland Avenue

Filed 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1930, to Oct. 15, 1930, that I last saw him alive on Oct. 15, 1930 and that death occurred, on the date stated above, at 12 30 M. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cholangitis

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? P.E.

(Signed) Edmund L. Goodall, M. D.

10/16, 1930 (Address) 735 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 10/17 1930

20 UNDERTAKER Henry U. Mears and Son ADDRESS 805 N. Calvert

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177 E 6141

E 6141

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1510 Eutaw Place 14-20 (Ward)

2-FULL NAME Emma James

(a) RESIDENCE NO. 1510 Eutaw Place St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	25	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Burnisher

(b) General nature of industry, business, or establishment in which employed (or employer) Picture Frame

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

10 NAME OF FATHER Walter McPherson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Martha Blackburn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md.

PARENTS

14 Informant Mr. Walter McPherson

(Address) 1945 E. 31 St.

15 Filed 1930 HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accadint ovr dose Ergot

Heart Disease (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 370 Eutaw Place (duration) yrs. mos. ds.

Signed F. B. Luck M. D.

(Coroner) Coroner

Oct 16 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem Roslyn Md. Date of Burial Oct 19 1930

20 UNDERTAKER J. F. McCully ADDRESS 130 E Fort

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61412 E 61412

CERTIFICATE OF DEATH

5-8 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 100 N. Front St. St., 5-8 Ward)

2-FULL NAME Joe. ~~Charles~~ Robinson.
Changed March 5. 1931.

(a) RESIDENCE NO. 100 N. Front St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	65	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. C.D.
(Address)

15 Filed 2 , 19 — HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 3, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

10/16 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS OCT 16 1930

UNIVERSITY OF MARYLAND
THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61413

E 61413

66

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 374 Forrest St. St. 5-8 Ward)

2-FULL NAME George Washington.(C)

(a) RESIDENCE NO. 270 N. Exeter St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: ----------

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md,
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) Do not know.
(State or country)

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) Do not know.
(State or country)

14 Informant Police Report. C.D.
(Address)

15 Filed ..., 19... HAMPSON JONES, M. D. Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 1, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto M Fernhardt, M. D.
10/1, 19 80 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL ... 19

20 UNDERTAKER: Commissioner Health. — ADDRESS OCT 16 1930

Spec.—1-30—M. & T.—250 Bks

E 61414 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 61414

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Beauchamp

(a) RESIDENCE NO. 608 Carroll ST., 21 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of

DATE OF BIRTH (month, day, and year) May 14th 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Child~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Charles Albert Beauchamp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edna M. Bradgiber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

PARENTS

14 Informant Charles A. Beauchamp 608 Carroll St.

15 Filed ... 19 HAMPSON JONES, M. D. Registrar RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1930, to Oct 12th, 1930, that I last saw him alive on Oct 12th, 1930, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

Rickets

(duration) about 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Geo. Yeager, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL OCT 16 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61415

CERTIFICATE OF DEATH

199

E 61415

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Johns Hopkins Hosp-12 (Ward)

City of Baltimore; (No.)

2-FULL NAME Rudolph Ourednik

(a) RESIDENCE NO. 2248 E Madison (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10 - 1915

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	15		5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) nil
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Chas Ouredenick

11 BIRTHPLACE OF FATHER (city or town) Bohemia
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Ruzicka

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Sophia Ouredenick
(Address) 2215 E madison St

15 Filed 19 HAMPSON Registrar

6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: while riding in stolen auto it collided with another auto then into truck overturning & catching afire

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lotrelly Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) I.S. Faure, M. D.

10 16. 1930 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 18 1930

ADDRESS

20 UNDERTAKER Emanuel Tasek 2406 Ashland ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61416

CERTIFICATE OF DEATH

18 SE 61416

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balto City Hospitals St., 25-32 Ward)

2-FULL NAME William A Shaffer

(a) RESIDENCE NO. 2459 Westport St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Shaffer

6 DATE OF BIRTH (month, day, and year) July 23 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	71	2	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Huckster
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Frederick Shaffer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto and

14 Informant Wm H. Shaffer
(Address) 2459 Westport St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Fracture L Hip

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. 2 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

10 16 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 10/18 1930

20 UNDERTAKER Meliani Cook

ADDRESS 1175 Hull

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61417

CERTIFICATE OF DEATH

154-002

E 61417

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1309 Cambria St. St. 25-77 Ward)

2-FULL NAME Clifford Lee Bibb.

(a) RESIDENCE NO. 1309 Cambria St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mo 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 16, 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0	1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Claude Bibb.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Isabelle Sullivan.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Isabelle Bibb. (mother)
(Address) 1309 Cambria St.

15 Filed C. HAMPSON JONES, M. D.
Registrar
By

6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.
10/16 19 30 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	10/18 19 30
20 UNDERTAKER Julian Cook	ADDRESS 1217 St. Paul Street

Cor.—10-10-29—A Co.—100 Bks.

E 61418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61413

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hospital St. 12-49 Ward)

2-FULL NAME Milton Weeks L'Ecluse

(a) RESIDENCE NO. Huntington, Long Island St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 11, 1908

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	22	—	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work aviator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Long Island
(State or country)

PARENTS

10 NAME OF FATHER Millon L. L'Ecluse

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Long Island

12 MAIDEN NAME OF MOTHER Julia Weeks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant Milton L. L'Ecluse
(Address) Huntington Long Island

15 Filed C. HAMPSON JONES, Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h— death on the day stated above.

The CAUSE OF DEATH was as follows:

Aeroplane Crash
Air Plane Accident
(Accidental)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

19 (Signed) [illegible], M. D.

10-16-1930 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York. N. Y.	Oct 16, 1930
20 UNDERTAKER E. LeRoy Stiffler, Inc	ADDRESS 125 E. North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

Edwin Lee Allen

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61419

CERTIFICATE OF DEATH

E 61419

REGISTERED NO. 16-002

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST. (If not in hospital, give WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edwin Allen

(a) RESIDENCE NO. Liberty Road (at Newbery Ave) ST. WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 9-1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Co

10 NAME OF FATHER Edwin Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mary J Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

Informant Mrs Allen

(Address) 4320 Falls Rd

71930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1930, to October 15, 1930, that I last saw him alive on October 15, 1930, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Laboratory

(Signed) H Workman, M. D.

, 19 (Address) West Balto Junction

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL Oct 18 1930

20 UNDERTAKER H A Marshall ADDRESS 3539 Falls Rd

Spec.—1-30—M. & T.—250 Bks.

61420 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61420

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Druid Hill Ave WARD 14-20)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Cook

(a) RESIDENCE NO. 2016 Druid Hill Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) July 2. 1890

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	3	12	12

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Hazlewood Md

10 NAME OF FATHER Samuel Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Harriett Wilkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Fannie B Cook

(Address) 2221 Druid Hill Ave

15 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 14th, 1930, to Oct 14, 1930, that I last saw her alive on Oct 12, 1930, and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

Immediately

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

10/14 1930 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem DATE OF BURIAL 10/17/30 19

20 UNDERTAKER Peter Hennessey ADDRESS 1128 Eutaw St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61421

CERTIFICATE OF DEATH

154-902 E 61421

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

City of Baltimore: (No. 1238 Riverside Ave. St., 24 33 Ward)

2 FULL NAME Arthur B. Barcroft Jr.

(a) RESIDENCE NO. 1238 Riverside Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 17, 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0	0	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Arthur B. Barcroft. Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Effie Jackson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Arthur B. Barcroft. Srl (father)
(Address) ewe: 1238 Riverside Ave.

Filed 1 1930, 19, HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

10/16 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Oct 17 1930

20 UNDERTAKER John J. Fahey Sons

ADDRESS 1318 Light St

Spec.—1-30—M. & T.—250 Bks

E 61422 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61422

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 S. Clinton St. ST. 76-7 WARD)

2-FULL NAME Edmund P. G. Yocum

(a) RESIDENCE NO. 304 S. Clinton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude A. Yocum

DATE OF BIRTH (month, day, and year) April 16 1842.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	5	29	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Philadelphia, Pa.

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known.

12 MAIDEN NAME OF MOTHER Margaret Houston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known.

14 Informant Gertrude A. Yocum

(Address) 304 S. Clinton St.

15 Filed OCT 17 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Oct 15, 1930, that I last saw him alive on Oct 15, 1930, and that death occurred, on the date stated above, at 5 30 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) Senility

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

10/16, 1930 (Address) 230 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL Oct 18 1930

UNDERTAKER George W. Zitkus

ADDRESS 1737 E Eager St

Spec—1-30—M. & T.—250 Bks.

E 61423 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61423

92

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 S. Fagley ST. 16-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Weaver

(a) RESIDENCE NO. 819 S. Fagley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Weaver

DATE OF BIRTH (month, day, and year) Nov. 4 1870

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	11	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md

10 NAME OF FATHER John S. Weaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

Informant Elizabeth Weaver

(Address) 819 S. Fagley St.

Rec'd OCT 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to 10/15, 1930, that I last saw h~~e~~ alive on 10/10, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/16 1930 (Address) 437 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Oct 19 1930

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E Eager St

Spec.—1-30—M. & T.—250 Bks

E 61424 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61424

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710-N. Bond St. ST., ... WARD)

2-FULL NAME Ellen Cullen

(a) RESIDENCE NO. 1710-N. Bond St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Cullen

7 DATE OF BIRTH (month, day, and year) 12/10/1857

AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
72	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Mathew William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) 4

PARENTS

14 Informant Mrs. T. J. Connor

(Address) # 1710 N. Bond St

15 [illegible] 19 171930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct 15, 1930, that I last saw h[illegible] alive on Oct 15, 1930, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

few minutes
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) Unk yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E H Hayward, M. D.

10/16, 1930 (Address) 1129 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem.

DATE OF BURIAL 10/18/30

20 UNDERTAKER George J Ruth Inc

ADDRESS 1735 Harford Ave

Spec.—1-30—M. & T.—250 Bks

E 61425 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61425

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 134 Fairce ST. 17-26 (WARD)

2-FULL NAME Emma Ewell

(a) RESIDENCE NO. 134 Fairce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE: Years 70; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Aberdeen Md

PARENTS

10 NAME OF FATHER Peter Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edward Ewell (Address) 134 Fairce St

Filed 10 17 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 30

17 I HEREBY CERTIFY, That I attended deceased from 9-15-, 1930, to 10-14-, 1930, that I last saw h[illegible] alive on 10-13, 1930 and that death occurred, on the date stated above, at 12-15 m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho-Pneumonia.

(duration) yrs. mos 5 da.

CONTRIBUTORY (Secondary) Cardio Vascular Renal Disease

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) A. L. Jackson, M.D.

10/17/30 (Address) 1500 Druid Park Drive

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Oct 17 1930

UNDERTAKER: Samuel Thomsen

ADDRESS 578 N Bdle

20—M. & T.—100 B—50L

61426

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 E 61426

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hopkins Hospital ST. 26-U WARD)

2-FULL NAME Catherine A. Raab

(a) RESIDENCE NO 413 N. Highland Ave ST., 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sep 4/29

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	11	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Nicholas J. Raab

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Catherine M. West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

Informant Nicholas J. Raab, Father

(Address) 413 N. Highland Ave.

Oct 17 1930 HAMPSON JONES, M. D. Registrar

71930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Hemorrhage. Severed right jugular vein. Accidently rolled from couch on broken nursing bottle.

(duration) ..... yrs. ..... mos ..... ds

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) ..... Coroner, M. D.

Oct. 17 1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL Oct 16 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Blks.

E 61427

Cost ✓

× 46

E 61427

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. 12-29 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma R Cost

(a) RESIDENCE NO. 406 Reisterstown Rd ST., WARD Pikesville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 42 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 30 1870

7 AGE: Years 68 | Months 10 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work: Housewife (wife of)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Reedyville Md

PARENTS

10 NAME OF FATHER John Cost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Bone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mrs Marriott Mrs Emerson Bond

15 Filed OCT 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1930, to Oct 17, 1930

that I last saw h[illegible]alive on Oct 17, 1930

and that death occurred, on the date stated above, at 1:40 A m.

The CAUSE OF DEATH* was as follows:

1 Respiratory failure incident

to Carcinoma of Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Primary Carcinoma of Ovaries

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wyatt Mortimer Jr. M. D.

(Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery | DATE OF BURIAL: Oct 20 1930

20 UNDERTAKER: F Elmer Rustentown Md | ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

61428

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61428

188-001

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq Hosp St. 19-27 Ward)

2-FULL NAME Edgar J (Schmidt) Schmidt

(a) RESIDENCE NO. 519 Virginia St., Ward Lower Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene (Schmidt) Schmidt

6 DATE OF BIRTH (month, day, and year) Oct-6-1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37	11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Captain
(b) General nature of industry, business, or establishment in which employed (or employer) Tug Boat
(c) Name of employer Consolidated Co

9 BIRTHPLACE (city or town) Bluestein Baltimore Co Md
(State or country)

PARENTS

10 NAME OF FATHER John J. (Schmidt) Schmidt

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Kane

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Marie (Schmidt) Schmidt
(Address) 519 Virginia

15 Filed OCT 17 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck in was driving in collision with train
crossing truck driving
(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) Multiple Skull Fracture
caused Edgar (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? 27 Md R R at Sawyers Lumber

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Kane, M. D.

(Address) 1939 Gay St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St John Cemetery Long Green	Oct 19 1930
20 UNDERTAKER	ADDRESS
Edward W. Conklin	924 E Eager

Spec.—1-30—M. & T.—250 Bks.

E 61429

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61429

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 ? Sarah Ann ST., 4-16 WARD)

2—FULL NAME Maggie Neal

(a) RESIDENCE NO. 743 A Sarah Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): W

6a If married, widowed, or divorced HUSBAND of or) WIFE of Henry

6 DATE OF BIRTH (month, day, and year) Aug 17 1883

7 AGE: Years 47; Months 1; Days 21; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's Co (State or country) Md

PARENTS

10 NAME OF FATHER Sam P. Briscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel V. Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Pete Neal

(Address) 310 N. Eutaw St.

15 Filed Oct 18, 1930. 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1930, to Oct 16, 1930, that I last saw h[illegible] alive on Oct 15, 1930, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Cleary, M. D.

, 19 (Address) 1[illegible] Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL 10/18/30

20 UNDERTAKER Jesse A. Redden

ADDRESS 1736 W. Baltimore St.

Cor.—10-10-29—A Co.—100 Blks.

E 61430

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61430

CERTIFICATE OF DEATH

188-004

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hospital St. 12-44 Ward)

2-FULL NAME Nelson Johnson, Jr.

(a) RESIDENCE NO. Aiken, S. C. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9, 1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	4	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work aviator
(b) General nature of industry, business, or establishment in which employed (or employer) Curtiss Wright Flying
(c) Name of employer Same

9 BIRTHPLACE (city or town) Aiken Co.
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Nelson Johnson

11 BIRTHPLACE OF FATHER (city or town) Aiken Co.
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Lillian Dwor

13 BIRTHPLACE OF MOTHER (city or town) Aiken Co.
(State or country) South Carolina

14 Informant Herbert Johnson,
(Address) Aiken, South Carolina

CT 171930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH was as follows:
Fractured base of skull
Burns
Multiple contusions
Accidental (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

10/17, 1930 (Address) [illegible]

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aiken, South Carolina

DATE OF BURIAL Oct 16, 1930

20 UNDERTAKER E. LeRoy Stuffle, Inc

ADDRESS 125 E. North Ave

Spec.—1-30—M. & T.—250 Bks.

E 61431 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61431

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1808 Bolton ST. 14-20 (WARD)

2-FULL NAME Mary A Bennett

(a) RESIDENCE NO. 1808 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll County Md

PARENTS

10 NAME OF FATHER Benjamin Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elvira

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Carrie L Crook

(Address) 1808 Bolton St

15 Filed OCT 17 1930 19 G. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Oct 15, 1930, that I last saw h[illegible] alive on Oct 15, 1930, and that death occurred, on the date stated above, at 9P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis Eberle, M. D.

Oct 16 1930 (Address) 700 Hoch St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 18 1930
UNDERTAKER George L Smith	ADDRESS 532 Baltimore

Cor.—10-10-29—A Co.—100 Bks.

E 61432

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61432

CERTIFICATE OF DEATH

19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hosp St., 10 Ward)

2-FULL NAME How'd Harry Schalch

(a) RESIDENCE NO. 800 N. Bradford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of →

6 DATE OF BIRTH (month, day, and year) Jan 22 - 1914

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	16	8	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Harry Schalch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Kapscht

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant (Mary Schalch)
(Address) 800 N. Bradford St

15 [illegible] 1930. C. HAMPSON JONES, Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Stolen car in which he was riding collided with another auto and then with truck.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lobelby Hosp

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Turner, M. D.

10/17, 1930 (Address) 1939 W. Pratt Ellery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 20 1930

20 UNDERTAKER Hunt Funeral Home

ADDRESS 1406 Eutaw

IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Bks.

E 61433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 61433

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2324 W. Lanvale ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Smith

(a) RESIDENCE NO. 2324 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 2 mos. 17 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Smith

DATE OF BIRTH (month, day, and year) July 29th 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Lewis H. Hilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Sauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Albert C. Smith

(Address) 2324 W. Lanvale St

15 Filed 19 Registrar

OCT 17 1930 C. HAMPSON JONES M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 8 1930, to Oct 16 1930, that I last saw h alive on Oct 16 1930 and that death occurred, on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Stumps of leg followed by Gangrene (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) B. M. Sherman M. D.

10-17 1930 (Address) Sparks Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Fremont Ave and 30th

DATE OF BURIAL 10/18/1930

20 UNDERTAKER Albert J. Sm

ADDRESS 2503 Edmondson Ave

Spec. 5-16-29-1-F. S.—100 Bks.

E 61434 ✓ E 61434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 434 E Federal St (WARD)

2—FULL NAME Edna D Johnson

(a) RESIDENCE NO. 434 E Federal St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced — HUSBAND of (or) WIFE of: John D Johnson

6 DATE OF BIRTH (month, day, and year): Mar 1880

7 AGE — Years: 50 | Months: 7 | Days: 11 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

10 NAME OF FATHER: Albert Gantt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Letha Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John D Johnson

(Address): 434 Federal

15 Filed OCT 17 1930 J. C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 1x, 1930, to Oct 17, 1930, that I last saw her alive on Oct 16, 1930 and that death occurred, on the date stated above, at 5 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 4 yrs. 3 mos. da.

CONTRIBUTORY (Secondary): None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pillsbury M. D.

, 19 (Address) 817 Washington Blvd

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooks Chapel DATE OF BURIAL: Oct 17 1930

UNDERTAKER: Hammond Wright ADDRESS: 700 N Carrollton Ave

E 61435

Spec. 12-23-21 R.S.—400 Bks.

E 61435 ✓ E 61435

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No.) 1756 Carswell St. 9-46 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Emmett

(a) Residence No. 1756 Carswell St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George V Emmett

6-DATE OF BIRTH (month, day and year) July 12 1852

7-AGE 78 yrs. 3 mos. 4 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Germany

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Geo E V Emmett
(Address) 1756 Carswell St

15- Filed 10 17 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 16 1930

17- I HEREBY CERTIFY, That I attended deceased from August 4 1929 to October 16 1930 that I last saw h[illegible] alive on October 14 1930 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cardio vascular hypertension

(Duration) some yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

Signed George M Gothe M.D.
10/16 1930 (Address) 2436 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DATE OF BURIAL 10-18 1930

20-UNDERTAKER Chas A G Rohde ADDRESS 2327 Edmondson Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 61436

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61436

CERTIFICATE OF DEATH

74-001

REGISTERED NO. 21-24

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1011 West Grace ST.) (WARD)

2—FULL NAME William Mc. E. Ammerman

(a) RESIDENCE NO. 1011 West Grace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie May Ammerman

6 DATE OF BIRTH (month, day, and year): Oct 13 69

7 AGE — Years: 61 — Months: — — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Horse Shoer 036
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

10 NAME OF FATHER: Benjamin A.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Baynard.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Annie Mc Ammerman
(Address): 1011 W. Grace St

15 OCT 17 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1930, to Oct. 15, 1930, that I last saw h[im] alive on Oct. 14, 1930 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral apoplexy

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) J. A. Buchmer, M. D.

, 19 (Address) 375 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

20 UNDERTAKER: Wm Contson

DATE OF BURIAL: Oct 18 1930

ADDRESS: 2258 N Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61437 ✓ E 61437

E 61437

CERTIFICATE OF DEATH

185

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital St., 76 (Ward)

2-FULL NAME Richard A. Gregory

(a) RESIDENCE NO. 721 W. Lexington St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary A. Gregory

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
about	45	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Clarence Gregory
(Address) Falls Road

15 Filed ..... 19..... C. HANSON JONES, Registrar
By .....

17 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH was as follows: Accident Fell from Scaffold while painting Lawn 1020 Hollins St Fracturing Skull

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas H Brooke, M. D.

Oct 17. 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL 10/18 1930

20 UNDERTAKER W M ROUTSON — ADDRESS 2238 W North Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 61438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61438

CERTIFICATE OF DEATH.

100

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View City Hospitals

CITY OF BALTIMORE: (No. Bay View Md. ST. 6-4 WARD)

2-FULL NAME Charlotte Griffin

(a) RESIDENCE NO. 207 N. Durham St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE: Years 66 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant ..... (Address) Bay View Hosp

15 Filed 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-30

17 I HEREBY CERTIFY, That I attended deceased from 7-5-, 1930, to 10-12-30, 19....., that I last saw h... alive on 10-11-, 1930, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry McCulloch M. D.

10-12-, 1930 (Address) Bay View Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakesbury cemetery

DATE OF BURIAL at 19 30

20 UNDERTAKER Edward Bryan

ADDRESS 168 A Orleans St

Cor.—10-10-29—A Co.—100 Bks.

E 61439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 61439

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1017 Vine St. 18-76 Ward)

2-FULL NAME Nathan Frazier

(a) RESIDENCE NO. 1017 Vine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mns. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Colored | 5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Common
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) America

PARENTS

10 NAME OF FATHER Unknown Frazier

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant .....
(Address) .....

OCT 17 1930 J. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

about 1 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

Oct 16 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL 19 ..... ADDRESS .....

20 UNDERTAKER: Commissioner Health — OCT 17 1930

THE MORGUE

BY WM. E. WOODALL.

Spec.—1-30—M. & T.—250 Bks

E 61440 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61440

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 26-27 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miklaj Mochnacki

(a) RESIDENCE NO. none ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hospitals

Filed 10-16 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15-30

17 I HEREBY CERTIFY, That I attended deceased from 6-2-25, 19..., to 10-15-30, 19...

that I last saw him alive on 10-15-30, 19...

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic (duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency congestive (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? T. Home 2. Hospital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical examination

(Signed) Paul Padgett, M. D.

(Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Oct 18 1930

DATE OF BURIAL

20 UNDERTAKER F. W. Bazelwski

ADDRESS 1930 East-ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61441 E 61441

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH Warrington Apts.

CITY OF BALTIMORE: (No. 3808 N. Charles Street ST. 12-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Barkley Lindsay

(a) RESIDENCE NO. 3808 N. Charles Street ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Lindsay

6 DATE OF BIRTH (month, day, and year) July - 2 - 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Johnstown Penna

PARENTS

10 NAME OF FATHER John C. Barkley

11 BIRTHPLACE OF FATHER (city or town) Indiana Co. (State or country) Penna.

12 MAIDEN NAME OF MOTHER Adalade Milliken

13 BIRTHPLACE OF MOTHER (city or town) ? ? (State or country) Penna.

14 Informant Mrs. Jessie Barkley Wright (sister)

(Address) 21 Lindsay Ave. Dayton - Ohio.

15 1930. 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 3rd, 1930 ... to Oct 16, 1930, that I last saw her alive on Oct 16, 1930 and that death occurred, on the date stated above, at 2.45 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac dilitation - Myocardial degenerations.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Diabetes M.

(duration) 16 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Harry D. McCarty M. D.

10-17-1930 (Address) 37 W. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 19

20 UNDERTAKER Sturdy Mowen Company

ADDRESS 108-20 North Ave.

Spec.—1-30—M. & T.—250 Bks.

E 61442 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61442

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Reisterstown Road & Kate Ave ST.) 15-58 (WARD)

2-FULL NAME Adaline Hoff Shirley

(a) RESIDENCE NO. Reisterstown Road & Kate Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Henry C. Shirley

6 DATE OF BIRTH (month, day, and year) Nov 7 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Hoff

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Germany

12 MAIDEN NAME OF MOTHER Adaline Whitney

13 BIRTHPLACE OF MOTHER (city or town) Boston

(State or country) Mass.

14 Informant Mrs. Joseph Whitney Shirley (son)

(Address) Reisterstown Road & Kate Avenue

15 Filed Oct 17 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct 16, 1930,

that I last saw h... alive on Oct 16, 1930,

and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

Dropsy

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Oct 16, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Oct 15 1930

ADDRESS

20 UNDERTAKER Stewart & Mowen Company - 118-20 North Ave.

Spec.—1-30—M. & T.—250 Bks

E 61443 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61443

CERTIFICATE OF DEATH.

× 124

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4-30 Ward)

2-FULL NAME Charles J. Grant

(a) RESIDENCE NO. Sykesville, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Agnes Grant

6 DATE OF BIRTH (month, day, and year) Feb 3 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jno. T. Grant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anne Flannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant W. H. Grant

(Address) Sykesville Md.

15 Filed 7-1930 19 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1930, to Oct. 17, 1930, that I last saw h.(illegible) alive on Oct. 17, 1930, and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Emphysema of Gall-bladder

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 16, 1930

No

Was there an autopsy? Necropsy

What test confirmed diagnosis? —

(Signed) George H. Yeager M. D.

19 17 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. View Cemetery	Oct 20 1930
20 UNDERTAKER	ADDRESS
Frew & Son	Sykesville Md.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61144 — 129 E 61144

REGISTERED NO. 15-61

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2900 Windsor Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Rebecca Tydings

(a) RESIDENCE NO. 2900 Windsor Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of J. Reid Tydings Sr.

DATE OF BIRTH (month, day, and year) Jan. 16, 1883,

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	9		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. (State or country) Md.

10 NAME OF FATHER Lewis F. Taeuber

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary F. Vickery

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant J. Reid Tydings

(Address) 2900 Windsor Ave.

Filed OCT 17 1930, G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 - 1930, to Oct 16, 1930, that I last saw h[illegible] alive on Oct 16 1930 and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Pancreatitis, Nephritis, Cardiac

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis etc.

(Signed) A. M. Smith, M. D.

10/19, 1930 (Address) 1117 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery, DATE OF BURIAL Oct. 20, 1930,

20 UNDERTAKER Wm. C. Black ADDRESS 921 N. Broadway

Spec.—1-30—M. & T.—250 Bks

E 61445 HEALTH DEPARTMENT—CITY OF BALTIMORE 46 E 61445

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2234 E. Biddle ST.) 8-12 WARD)

2-FULL NAME Wilhelmina Kirchner

(a) RESIDENCE NO. 2234 E. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24 1862

7 AGE: Years 68 | Months 8 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown Germany

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown
12 MAIDEN NAME OF MOTHER Amelia Grutza
13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant Annie Thatcher (Address) 2234 E. Biddle St.

15 FILED Oct 7 1930 H. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1930

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to Oct 15, 1930, that I last saw h[er] alive on Oct 15, 1930, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Respiratory Paralysis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cancer of the Uterus
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of June 1 30
Was there an autopsy? no
What test confirmed diagnosis? Microscopic findings
(Signed) H. B. Kerner, M. D.
Oct. 19 30 (Address) 1301 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Immanuel Cemetery — DATE OF BURIAL . 19

20 UNDERTAKER Frederick Lasamore Sons — ADDRESS 7401 Belair Rd

Spec.—8-16-29—L. F. S.—100 Bks.

E 61446

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61446

CERTIFICATE OF DEATH

REGISTERED NO. 84

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Guilford ST. 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Hossbach Sr.

(a) RESIDENCE NO. 2225 Guilford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 9 mos. 12 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	Widower

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna M. Shirk

7 DATE OF BIRTH (month, day, and year) 1-3-1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Nettie Hossbach
(Address) 2225 Guilford

15 Filed 10 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1930, to Oct. 15, 1930,

that I last saw him alive on Oct 15, 1930

and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris -

- This attack about 3 hours -

(duration) 5 yrs. + mos. + ds.

CONTRIBUTORY (Secondary) Fatal Arteriosclerosis -

(duration) 10 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Based Clinical symptoms -

(Signed) A. F. Robinson, M. D.

10/17. 1930 (Address) Medical Arts Building -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL 10/18 1930

20 UNDERTAKER L. F. McCully

ADDRESS 130 S Fort

Spec.—1-30—M. & T.—250 Bks

E 61447

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61447

97-002

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST. 11-24 WARD)

2-FULL NAME Frank Taylor

(a) RESIDENCE NO. 1221 McCulloh St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced (HUSBAND) of or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Dec 7-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	33	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer Morgan State College

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ellen Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Laura Taylor

(Address) 1221 McCulloh St

15 10-17-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16/30

17 I HEREBY CERTIFY, That I attended deceased from 10/4/30, 19..., to 10/16/30, 19...,

that I last saw him alive on 10/14/30, 19...,

and that death occurred, on the date stated above, at 10:40 A.m.

The CAUSE OF DEATH* was as follows:

Acute Pan-sinusitis

(duration) — yrs. 2 mos — da.

CONTRIBUTORY (Secondary) ~~Acute Nephritis~~ Meningo-Encephalitis

(duration) ...yrs. — mos. 2 da.

18 Where was disease contracted if not at place of death? Baltimore, Md

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Leyko, M. D.

10/16 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem — DATE OF BURIAL Oct 18, 30

20 UNDERTAKER Samuel D Hensley — ADDRESS 1518 N Bond

Spec.—2-29-28—L. F. S.—500 Bks.

E 61448

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61448

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N Dolphin ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther S. Johnson

(a) RESIDENCE NO. 5 N Dolphin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	ed	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Jno. F. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Minnie Douglas

(Address) 202 Division St

Filed OCT 18 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15-30

17 I HEREBY CERTIFY, That I attended deceased from May 30, to 10-15, 30

that I last saw her alive on 10-15, 30

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 425 N. Caroline St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Mem Park

DATE OF BURIAL Oct 18, 1930

20 UNDERTAKER Edward F. Wesley

ADDRESS Biddle

Spec.—7-17-26—A Co.—200 Bks.

61449

John Thomas Bell

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 61449

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1421 McCulloh St. 14-20 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Bell

(a) RESIDENCE NO. 1421 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta Bell

6 DATE OF BIRTH (month, day, and year): Aug 26-1867

7 AGE: Years 63 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

(c) Name of employer: B & O R R

9 BIRTHPLACE (city or town) Richmond

(State or country) Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant. Henrietta Bell

(Address) 1421 McCulloh St

15 [illegible] 187930

C. HAMPSON JONES, M. D. Registrar

Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1930 to Oct 15 1930

that I last saw h[illegible] alive on Oct 15 1930

and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Chas F Chevalier M. D.

Oct 16 1930 (Address) 3012 Li Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial Oct 19 1930

20 UNDERTAKER Samuel F Hensley

ADDRESS 578 Belair

very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

61450 E 61450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH South Baltimore General Hospital ST. 13-59 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO.

2-FULL NAME Aaron Hester

(a) RESIDENCE NO. 2532 Druid Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Tillie Hester

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Robert Hester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Louise Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Hospital records (Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15-30

17 I HEREBY CERTIFY, That I attended deceased from October 11, 1930, to October 15, 1930, that I last saw him alive on October 15, 1930, and that death occurred, on the date stated above, at 10⁰⁰ P m.

The CAUSE OF DEATH* was as follows:

Luetic cardiovascular disease

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral insufficiency (duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? at Havre de Grace, Md

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph D. Laukaitis, M. D.

(Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem DATE OF BURIAL Oct 17, 1930

20 UNDERTAKER Edward H. Hensley ADDRESS 1728 Bolton

18703

Cor.—10-10-29—A Co.—100 Bks.

Catherine Breckenridge

61451

HEALTH DEPARTMENT—CITY OF BALTIMORE

1930 E 61451

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1218 Madison Ave. St. 11-24 Ward)

2-FULL NAME Catherine Breckenridge

(a) RESIDENCE NO. 900 Block McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1909

7 AGE: Years 21 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wilkes Co. Ga

PARENTS

10 NAME OF FATHER: Robt Breckenridge

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga

12 MAIDEN NAME OF MOTHER: Sydney Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ellen Breckenridge. (Address) 1226 Madison Ave.

Filed OCT 16 1930 HAMPSON JONES, Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Hemorrhage due to Stab wound of heart and Lung (duration) Instantaneous yrs. mos. ds.

CONTRIBUTORY (Secondary) Stab with Knife (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1218 Madison Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

Oct 17 (Address) Bon Secours

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Oct 18 1930

20 UNDERTAKER: Samuel Hensley

ADDRESS: 1911 Eutaw Pl

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 61452

E 61452

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH 1419 Orleans st REGISTERED NO.

CITY OF BALTIMORE: (No. 1419 ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Marshall

(a) RESIDENCE NO. 1419 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harrison Marshall

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE: Years 81; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): V. a

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Harrison Marshall

(Address): 1419 Orleans st

15 Filed OCT 15 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-16-30

17 I HEREBY CERTIFY, That I attended deceased from 10-13-30, 19 30, to 10-16-30, 19 30, that I last saw h alive on 10-15-30, 19 30 and that death occurred, on the date stated above, at 8 16 14 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Cozier, M. D.

10-17-1930 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk V. a

DATE OF BURIAL: at 18 1930

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Orleans st

Spec.—1-30—M. & T.—250 Bks.

E 61453 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61453

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1202 McElderry St. 5-8 WARD)
2-FULL NAME Irvin A. Hawkins
(a) RESIDENCE NO. 1202 McElderry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: C
5 Single, Married, Widowed, or Divorced, (write the word): Single
6a If married, widowed, or divorced HUSBAND of (or) WIFE of
7 DATE OF BIRTH (month, day, and year) 1908
7 AGE: Years 22; Months; Days; If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country): Balto Md
PARENTS
10 NAME OF FATHER George A. Hawkins
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md
12 MAIDEN NAME OF MOTHER Clementine Hunter
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md
14 Informant: Clementine Hawkins
(Address) 1202 McElderry St
C. THOMPSON JONES, M.
Filed 1930 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 30
17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct. 16, 1930, that I last saw him alive on Oct. 10, 1930, and that death occurred, on the date stated above, at 9.50 A m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) yrs. mos ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Wm. Duncan M. D.
(Address) 1006 Edmondson
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.
DATE OF BURIAL: 10-19 1930
20 UNDERTAKER: Bysor & Wright
ADDRESS: 1218 McElderry St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61454

CERTIFICATE OF DEATH

74-21 61454

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2010 Cold Spring Lane St. 27-56 Ward)

2-FULL NAME James E Smith

(a) RESIDENCE NO. 2010 Cold Spring Lane St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49	0	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER: J E Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER: Fannie Frances

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant: Ruby Smith
(Address) Govans Md

15 Filed OCT 13 1930 HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

D T Pleurisy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hampson Jones, M. D.

Oct 17 1930 (Address) 7622 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnson	Oct 19 1930
20 UNDERTAKER	ADDRESS
Joseph A Lively	4097 Mound St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 61455

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61455

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 W. Lex ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Martin

(a) RESIDENCE NO. 1218 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Stevedore

(c) Name of employer: Atlantic Coast Co,

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Robt Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Percy Pinkett

(Address) 913 Pearre St.

15 Filed OCT 19 1930 19 C. HAMPSON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 / 30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1930 to Oct. 15 1930

that I last saw h alive on Oct. 15 1930

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wolfe Lee, M. D.

10/15 19 30 (Address) 1218 W Lex

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hopton Va — DATE OF BURIAL: Oct 19 1930

20 UNDERTAKER: Joseph A Lucy — ADDRESS: 409 Mount St

1-30—M. & T.—100 B—50L

E 61456 × 90 ✓ E 61456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 25-72

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Washington Boulevard ST. WARD) Pronounced dead. St Agnes Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John K. Morris

(a) RESIDENCE NO. Richmond Hill N Y ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva K. Morris

6 DATE OF BIRTH (month, day, and year) Aug 13/83

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	47	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer 0-30
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Vandine Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Va

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George E. Lowery

(Address) Brooklyn N.Y.

15 Filed OCT 18 1930 C. HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Apoplexy - Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Brooks M. D. Coroner

Oct 17 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Long Island N Y

DATE OF BURIAL 10/18/30

UNDERTAKER Massey & Wetzler

ADDRESS 401 Edmondson Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

63457 — 113 — L 61457

CERTIFICATE OF DEATH.

REGISTERED NO. C 76-36

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 420 Detroit ave ST.) (WARD) 8th

2-FULL NAME Mary A Robbins
(Residence in Baltimore: No. 420 Detroit ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Femal
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Singl

6-DATE OF BIRTH: April 17 (Month) (Day), 1930 (Year)

7-AGE: ...yrs. 6 mos. ...ds.
If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Balto md

PARENTS.
10-NAME OF FATHER: Moses. Robbins
11-BIRTHPLACE OF FATHER (State or Country): Balto City
12-MAIDEN NAME OF MOTHER: Martha Lynch
13-BIRTHPLACE OF MOTHER (State or Country): Delaware

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant) Moses. Robbins
(Address) 420 Detroit Ave

15-
OCT 18 1930
C. HAMPSON JONES, M. D.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: ~~Gastro Enteritis~~ Enteritis (Enteritis)

(Duration) ...yrs. ...mos. 3 ...ds.

CONTRIBUTORY (Secondary)
(Duration) ...yrs. ...mos. ...ds.

(Signed) James M Fenton M. D.
(Coroner)
Oct 17 1930 (Address) 700 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: St Matthews — DATE OF BURIAL: Oct 18, 1930

20-UNDERTAKER: John Ellert — ADDRESS: 2008 Orleans

Spec.—1-12-23—M&T.—500 Blks.

E 61458

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61458

162

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2135 E Chase St., 8-12 WARD)

2-FULL NAME Sola Killian

(a) RESIDENCE NO. 2135 Chase St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 16 30

7 AGE — Years: — Months: — Days: 1 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Joseph Killian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Sola Senft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant (Address) Joseph Killian 2135 E Chase St

15 Filed Oct 18 1930 . 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 16 . 1930 . to Oct 17 . 1930 .

that I last saw he alive on Oct 17 . 1930 ,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute Abscess

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William J. Roarer M. D.

(Address) 801 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 18 1930

20 UNDERTAKER Wm. E. Crockson 1906 Eastern Ave

ADDRESS Oakland (

Spec.—2-29-28—L. F. S.—500 Bks.

E 61459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 61459

REGISTERED NO. 12-51

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2613 Bernard ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Dix

(a) RESIDENCE NO. 2613 Bernard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Florence A Dix

6 DATE OF BIRTH (month, day and year): 12 [illegible] 1881

7 AGE: Years 49 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: George H. Dix

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Bettie Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Florence A. Dix (wife)

(Address) 2613 Bernard St.

Filed OCT 1930 THOMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17, 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 1930, to Oct 17 1930

that I last saw him alive on Oct 17 1930

and that death occurred, on the date stated above, at 2.05 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Pulmonary (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 5.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. E. Richardson M. D.

Oct 17 1930 (Address) 1127 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cem Hampden

DATE OF BURIAL: Oct 20 1930

20 UNDERTAKER: Walter Davis

ADDRESS: 318 E Chestnut Ave

Spec.—1-30—M. & T.—250 Bks

E 61460 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61460

75-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4503 Fernhill Ave ST. 28-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amalia Elise Louise Mohl

(a) RESIDENCE NO. 4503 Fernhill Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Henry Mohl

6 DATE OF BIRTH (month, day, and year) Sept 26/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Ludwig Luther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine D. Stenille

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Mohl

(Address) 4503 Fernhill Ave

15 Filed Oct. 19 1930 STAMP JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Oct 17, 1930,

that I last saw h[illegible] alive on Oct 12, 1930,

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Cancer

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edward J Mills, M. D.

, 19 (Address) 5142 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Oct 20 1930

20 UNDERTAKER Harry A Timmons & Son

ADDRESS 4204 Ridgewood Ave

Spec.—1-10-21—M&T—1500 Blks.

E 61461

E 61461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6007 York Road, ST. 27-44 WARD)

2-FULL NAME Mrs Sophia Elizabeth Will

(a) RESIDENCE No. 6007 York Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of John Will

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1839

7 AGE — Years: 90 — Months: 11 — Days: 16 — If LESS than 1 day, 11 hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER John Henry Garner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Dorthea Stieckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Son (Address) 6007 York Road

Filed OCT 18 1930 By: D. HAMPSON JONES, JR.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Oct. 17, 1930, that I last saw her alive on Oct. 17, 1930, and that death occurred, on the date stated above, at 11 20 A.m.

The CAUSE OF DEATH* was as follows:

Adeno-Carcinoma of Bladder

(duration) yrs. 2 mos 17 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests.

(Signed) W E Cole, M. D.

10-17, 1930, (Address) 6007 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

UNDERTAKER: Robert Brooks & Son

DATE OF BURIAL 10/20 1930

ADDRESS Calhoun Holl...

TION IS very important. See instructions on back of certificate.

E 61462

Spec.—8-16-29—L. F. S.—100 Bks.

E 61462 HEALTH DEPARTMENT—CITY OF BALTIMORE 90

CERTIFICATE OF DEATH

1—PLACE OF DEATH Good Shepherd General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1512 Gilmore ST. 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles H Parker

(a) RESIDENCE NO. 2005 E Eutaw ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hester Parker

6 DATE OF BIRTH (month, day, and year) Nov 15 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J. Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jennie F. Jones

(Address) 1909 N Fulleare

15 Filed OCT 18 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 19 30 to Oct 16 19 30, that I last saw h[illegible] alive on 10/16-30 19 and that death occurred, on the date stated above, at 10 30A m.

The CAUSE OF DEATH* was as follows: Mitral Insufficency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Edema

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W R Boykin, M. D.

19 (Address) 1512 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 10/19 1930

20 UNDERTAKER Thomas E Kelso

ADDRESS 1303 Prestman St

8pec.—1-30—M. & T.—250 Blks.

E 61463 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61463 S 24

CERTIFICATE OF DEATH.

27-47 22

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2-FULL NAME Anna Mertz

(a) RESIDENCE NO. 1106 Wilkens Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of or) WIFE of None

6 DATE OF BIRTH (month, day, and year) June 5/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md—

PARENTS

10 NAME OF FATHER James Mertz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md—

12 MAIDEN NAME OF MOTHER Amelia Gulf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md—

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 C. HAMPSON JONES, Registrar

OCT 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18/30

17 I HEREBY CERTIFY, That I attended deceased from 10/16/, 1930, to 10/18, 1930, that I last saw her alive on 10/18, 1930, and that death occurred, on the date stated above, at 7:40 Am.

The CAUSE OF DEATH* was as follows:

Poliomyelitis.

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Res. home No above

Did an operation precede death? No Date of No

Was there an autopsy? No.

What test confirmed diagnosis? Spinal fluid, clinical course

(Signed) J. C. Geo Dorsey, M. D.

10/18, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

UNDERTAKER Philip Herwig

DATE OF BURIAL Oct 21, 1930

ADDRESS 2016 Orleans St

Spec.—1-30—M. & T.—250 Bks.

E 61464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 112

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

2—FULL NAME Thelma Finch

(a) RESIDENCE No. 237 No. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
Female	Black	Child

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 19, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Child~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Herman Finch

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Pattie Short

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Oct. 14, 1930, that I last saw her alive on Oct. 14, 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Enteritis and diarrhoea

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. P.E. & autopsy

(Signed) C. Goodwin M. D.

10/15, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

UNDERTAKER H. G. Elliott

DATE OF BURIAL Oct 18 1930

ADDRESS 1715 Ashland Ave

Spec.—1-30—M. & T.—250 Bks.

E 61465

E 61465 HEALTH DEPARTMENT—CITY OF BALTIMORE

132

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Sinai Hospital ST. 4-20 WARD)

2-FULL NAME Nathan Hess

(a) RESIDENCE NO. 2042 Linden Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 31, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen'l Commission

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Moses Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss. Hess (Address) 2042 Linden Ave

15 Filed 10-18-1930 H. C. HAMPSON JONES, M. D. Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1930, to Oct. 17, 1930, that I last saw h(e) alive on Oct. 17, 1930, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy Bladder with Bladder Calculi

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Post operative Surgical Shock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 17, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles Robert Colvin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chev Shalom Cem.

DATE OF BURIAL 10/19/1930

20 UNDERTAKER Harold Sondheim & Son

ADDRESS 1902 Eutaw Place

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-002

E 61466

E 61466

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1737 Ellsworth St (WARD) 8

2-FULL NAME Ida L. Miller

(a) RESIDENCE No. 1737 Ellsworth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Miller

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
75.	1855	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Delta, Pa.

PARENTS

10 NAME OF FATHER Daniel Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Ida Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. Cowda (Address) 1737 Ellsworth St

15 Filed 10/18/30 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16/1930

17 I HEREBY CERTIFY, that I attended deceased from Oct 7, 1930 to Oct 13, 1930

that I last saw h[illegible] alive on Oct 13, 1930

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Diarrhoe

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical

(Signed) [illegible] M. D.

(Address) 1445 E Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta Pa

DATE OF BURIAL 10/19/30

UNDERTAKER R. O. Williams

ADDRESS 1515 McElderry

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61467

185 E 61467

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balt City Hospital St., 16-22 Ward)

2-FULL NAME William H Sandy

(a) RESIDENCE NO. 1120 N Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cannie M Sandy

6 DATE OF BIRTH (month, day, and year) Jan. 18. 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70	8	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 062
(b) General nature of industry, business, or establishment in which employed (or employer) night watch
(c) Name of employer Man

9 BIRTHPLACE (city or town) .....
(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown Sandy

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Cannie Sandy
(Address) 1120 N Monroe St

15 Filed ....., 19.. HAMPSON JONES, M. D. Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture R ankle, fell down stairs in Hospital

Accident

(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

10/17 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine — DATE OF BURIAL 10/20 1930

20 UNDERTAKER William Cook — ADDRESS 2172 Pond St

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61468 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61468

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. 3-5 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Chinn

(a) RESIDENCE NO. 906 E. Lombard st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Yellow	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Henry Chinn

6 DATE OF BIRTH (month, day, and year) June 21, 1910

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	20	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry How

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Emma Eckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1930, to Oct. 18, 1930, that I last saw her alive on Oct. 18, 1930, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Seaver, M. D.

10-18-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 10/21 1930

20 UNDERTAKER William Cook

ADDRESS 1212 E Fayette St

Spec.—1-30—M. & T.—250 Bks.

E 61469 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61469

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4216 Harford Ave ST. 27-45 (WARD)

2-FULL NAME Arabine N. Farnham

(a) RESIDENCE NO. 4216 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced, (write the word)~~
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ or) WIFE of Otis C. Farnham

6 DATE OF BIRTH (month, day, and ~~year~~) Apr 14th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82		6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Hampden Maine

PARENTS

10 NAME OF FATHER Peter Newcomb

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Hampden Maine

12 MAIDEN NAME OF MOTHER Melinda Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Hampden Maine

14 Informant Mrs Lynette Gerding

(Address) 4216 Harford Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

OCT 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to Oct. 17, 1930

that I last saw her alive on Oct 17, 1930,

and that death occurred, on the date stated above, at 11:55 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Urinary Bladder

(duration) yrs. 6 mos 17 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Clinical

19 (Signed) Chas J Kinsey, M. D.

Oct 18, 1930 (Address) 2700 Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cemetery Brewer, Maine

DATE OF BURIAL 10/20/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

E 61470

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61470

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T. B.)

CITY OF BALTIMORE: (NO. ST., WARD)

2-FULL NAME James Blaney

(a) RESIDENCE NO. 740 George st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Blaney

6 DATE OF BIRTH (month, day, and year) 1901 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Westminster

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Blaney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

Filed 19 1930, 19 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1930, to Oct. 16, 1930, that I last saw him alive on Oct. 16, 1930, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) David Lumen, M. D.

10-17-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Cem.

DATE OF BURIAL Oct 20, 30

20 UNDERTAKER Eugene Waters

ADDRESS 1433 Edmonson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 61471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 46E 61471

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 Riggs av ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary A. Rusk

(a) RESIDENCE NO. 1826 Riggs av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if foreign birth 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Wh.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Rusk

6 DATE OF BIRTH (month, day, and year) May 11th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Darby Ambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng.

12 MAIDEN NAME OF MOTHER Jane Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eng.

14 Informant Edward Rusk

(Address) 1826 Riggs av.

15 Filed 19 1930 C. HAMPSON JONES, M. D. Registrar

Par NRB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17/30

17 I HEREBY CERTIFY, That I attended deceased from May, 1930, to Oct. 17, 1930, that I last saw h[illegible] alive on Oct. 17, 1930 and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Referred Hospital

Card & exam.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hyper of Lungs & Abdomen & Kidneys

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

Oct 17 1930 (Address) 1605 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery

DATE OF BURIAL Oct 20 1930

20 UNDERTAKER A Flask

ADDRESS 1013 W. Fulton Ave

Spec.—1-30—M. & T.—250 Bks

E 61472

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61472

CERTIFICATE OF DEATH.

REGISTERED NO. 100,001

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 10-13 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Sayles

(a) RESIDENCE NO. 1444 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown (1847)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry Sayles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Records of Balto. City Hospitals

15 Filed ..... 19..... C. HAMPSON JONES, M. D., Registrar

By .....

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-17-30

17 I HEREBY CERTIFY, That I attended deceased from 5-5-27, 19..., to 10-17-30, 19...,

that I last saw her alive on 10-17-30, 19..., 4 A. m.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, cerebral,
Senile psychosis.

(duration) 3½ yrs. ... mos ... da.

CONTRIBUTORY (Secondary): Bronchopneumonia.

(duration) ... yrs. ... mos. 3 da.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Dane Padget, M. D.

10-17, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	10/21/1930
20 UNDERTAKER	ADDRESS
Mrs Orbed L. Bailey	1421 Jefferson St

Spec.—1-10-21—M&T—1500 Bks.

E 61473

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61473

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Howard A Kelly Hospital

CITY OF BALTIMORE: (NO.) 1418 Eutaw Place ST. WARD) 14-20

2-FULL NAME Emma Patton Ewing

(a) RESIDENCE NO. San Antonio Texas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William K. Ewing

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Curwensville Pa.

PARENTS

10 NAME OF FATHER Charles E. Patton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Curwensville Pa

12 MAIDEN NAME OF MOTHER Mary Beggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburg Pa

14 Informant Dr. Edmund Gros (Address) Paris France

15 C. HAMPSON JONES, M. D. 19 Registrar

1 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18th 2 PM 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 11th, 1928 to Oct 18 1930

that I last saw h alive on Oct 18 1930

and that death occurred, on the date stated above, at 2 PM m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma

(Primary Breast

(duration) 3 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in Paris France

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Tissue Taken

(Signed) Curtis J Burnam, M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL San Antonio Texas — DATE OF BURIAL Oct 19 1930

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W North ave

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 61474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61474

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 12-49 WARD)

2-FULL NAME Mrs Peggie Driver

(a) RESIDENCE NO. Selma, Alabama ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (~~HUSBAND'S~~ or) WIFE of: John Driver

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 45 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alabama

PARENTS

10 NAME OF FATHER: Henry Lathatham

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant (Address): Hospital Records.

15 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1930, to Oct 19, 1930, that I last saw her alive on Oct 19, 1930, and that death occurred, on the date stated above, at 1 45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal obstruction

(duration) yrs. mos. 42 ds.

CONTRIBUTORY (Secondary) Post operative shock (duration) yrs. mos. 18 hours ds.

18 Where was disease contracted if not at place of death? Selma, Ala.

Did an operation precede death? yes Date of Oct 18, 1930

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Ralph G. Wills, M. D.

19 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Selma-Ala — DATE OF BURIAL: Oct 19 1930

20 UNDERTAKER: W. T. McKnee & Sons — ADDRESS: Montgomery

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61475 ✓ E 61475

CERTIFICATE OF DEATH

88

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 Lloyd ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Gerson Kaplan

(a) RESIDENCE NO. 125 Lloyd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Philip Kaplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Kaplan

(Address) 3817 Norfolk Ave

Filed OCT 19 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18/30

17 I HEREBY CERTIFY, That I attended deceased from October 7, 1930, to October 18, 1930, that I last saw him alive on October 18, 1930, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as followa:

Acute myocarditis

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Pulmonary Emphysema

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical p

(Signed) Louis Shamon, M. D.

Oct 18 1930 (Address) 1705-7 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

20 UNDERTAKER Jos Lurman & Bro

DATE OF BURIAL Oct 19 1930

ADDRESS 1127 E Balto st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61476

CERTIFICATE OF DEATH

90 E 61476

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2109 Orleans ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjamin Fox

(a) RESIDENCE NO. 2109 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

PARENTS

10 NAME OF FATHER Abe Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Fox

(Address) 2467 Shirley ave

15 Filed OCT 19 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Oct 19, 1930, that I last saw h[illegible] alive on Oct 18, 1930 and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel G. Wolfe, M. D.

10/19 1930 (Address) 1331 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebron Rosedale

DATE OF BURIAL Oct 19 1930

20 UNDERTAKER Sol Thompson & Bro

ADDRESS 1171 E. Baltimore

Spec.—1-30—M. & T.—250 Bks

E 61477 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61477

66

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 26-37 ST. WARD)

2-FULL NAME Robert C Ebling (EBERLING)

(a) RESIDENCE NO. 2632 Memphil Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Eberling

6 DATE OF BIRTH (month, day, and year) Nov 4 1889 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Unknown Maryland

10 NAME OF FATHER John G Eberling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Germany

12 MAIDEN NAME OF MOTHER Unknown Margaret Eberer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Maryland

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 10 1930 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16-30

17 I HEREBY CERTIFY, That I attended deceased from 10-13-30, 19, to 10-16-30, 19, that I last saw him alive on 10-16-30, 19, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Psychosis, toxic, alcoholic Korsakow's Syndrome (duration) yrs. mos 11 da.

CONTRIBUTORY (Secondary) Alcoholism, chronic (duration) 6 yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinic & exam. history.

(Signed) Paul Padget, M. D.

10-17 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

20 UNDERTAKER Joseph A Farley Inc

DATE OF BURIAL 10/20/30

ADDRESS Fayette

Spec.—1-30—M. & T.—250 Bks

E 61478 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61478

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 16-26

CITY OF BALTIMORE: (NO. (Handy) ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Eailor

(a) RESIDENCE NO. 1117 Harlem ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of James Eailor

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Howard Bishop

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 HAMPSON JONES, M. D. Registrar

19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 11, 19 30, to Oct. 16, 19 30, that I last saw her alive on Oct. 16, 19 30, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary) Tuberculous meningitis. (duration) yrs. mos. 1 week ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Tenner, M. D.

10-17, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Chapel Cemetery, Howard Co. Md. DATE OF BURIAL Oct. 19, 19 30

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St.

Spec.—1-30—M. & T.—250 Bks.

E 61479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61479

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 409 Poland Ave ST. 13-52 WARD)

2-FULL NAME James E. Schaffer

(a) RESIDENCE NO. 409 Poland Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of WIFE of: Alice M. Schaffer

6 DATE OF BIRTH (month, day, and year): 2/20/1870.

7 AGE: Years 60. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self.

9 BIRTHPLACE (city or town) Carroll co. Md.

(State or country)

10 NAME OF FATHER Lewis Schaffer.

11 BIRTHPLACE OF FATHER (city or town) Carroll co.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Susana Stull

13 BIRTHPLACE OF MOTHER (city or town) Carroll co.

(State or country) Md.

PARENTS

14 Informant Alice M. Schaffer Wife.

(Address) 409 Poland Ave.

Registered 19 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1930 to Oct 17 1930.

that I last saw h alive on Oct 17 1930. 2 20 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis - Fibrillation.

Arteria Sclerosis.

Chronic Nephritis

CONTRIBUTORY (Secondary) Cardiac Dilatation - Uremia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Finding

(Signed) Dr. Wesley Edmondson M. D.

(Address) 1000 Edmondson Ave

10/18/1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls Arcadia Md.

DATE OF BURIAL: 10/21/1930.

20 UNDERTAKER: Grace H Burgess.

ADDRESS: 363 Fulton Ave.

Spec.—1-30—M. & T.—250 Bks

E 61480 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61480

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 13-57 ST. WARD)

2-FULL NAME Sarah E. Johnson

(a) RESIDENCE NO. 914 W. 38th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1.7c yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Jane Nicholas Confederation Johnson

6 DATE OF BIRTH (month, day, and year): Nov 1 1859.

7 AGE: 70 Years 71 Months 11 Days 17

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Edward Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown.

12 MAIDEN NAME OF MOTHER: Eliza Atchison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Dead. (Address) BALTIMORE CITY HOSPITALS

Filed ..... 19 1930 ..... 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 18, 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1928, to Oct 18, 1930, that I last saw her alive on Oct. 18, 1930, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis UNKNOWN.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

10-19, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cemetery

DATE OF BURIAL: 10/21/1930

20 UNDERTAKER: J. Forrest F. Burger

ADDRESS: 3621 Falls Rd

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Ridgell ✓

E 61481

9 E 61481

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. City R. Fort ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M. Ridgell.

(a) RESIDENCE NO. City R. Fort Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) June 5, 1930.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4.	14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Infant. 60

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John W. Ridgell.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Nellie Yewell.

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Nellie Ridgell (Mother).
(Address) City R. Fort Ave.

15 Filed OCT 19 1930, 19 [illegible] Registrar

T 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19/30

17 I HEREBY CERTIFY, That I attended deceased from 10/15 1930, to 10/19 1930, that I last saw h[illegible] alive on 10/19 1930, and that death occurred, on the date stated above, at 8. a m.

The CAUSE OF DEATH* was as follows:

Peritonitis

From History. (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Gastric Enteritis + Convulsions (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. J. Tunnington M. D.

10/19 1930 (Address) 2102 Mt Holly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL 10 20 1930

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Eutaw

Spec.—1-30—M. & T.—250 Bks.

E 244135 E 61482 ✓ E 61482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Roys

(a) RESIDENCE NO. 5005 Lerchwood av ST., Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louise Roys

6 DATE OF BIRTH (month, day, and year) Feb 11 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Eugene Ernest Roys

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Emma Vonatti

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 20 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-17-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Oct 17, 1930, that I last saw h[illegible] alive on Oct 17, 1930, and that death occurred, on the date stated above, at 8 10 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis — Myocardial failure

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-3-30

Was there an autopsy? [illegible]

What test confirmed diagnosis? Culture —

(Signed) Conrad Acton, M.D. M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL 10-20 1930

20 UNDERTAKER Mrs Chas A G Rohde — ADDRESS 2327 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

61483 E 61483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., H-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vivian Coleman

(a) RESIDENCE NO. 314 Myrtle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 28, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lawrence Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Catherine Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Locomoke City Md

14 Informant Lawrence Coleman

(Address) 314 Myrtle Ave

15 Filed OCT 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1930, to Oct 17, 1930, that I last saw her alive on Oct 17, 1930, and that death occurred, on the date stated above, at 6 40 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Hymen G. Jhee, M. D.

10/18, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Oct 20 1930

20 UNDERTAKER Jas. H. Jordan

ADDRESS 1027 Druid Hill

Spec.—1-30—M. & T.—250 Bks

E 61484 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61484

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 N Caroline ST. 10-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Green

(a) RESIDENCE NO. 608 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Widower

5a If married, widowed, or divorced HUSBAND of or ~~WIFE of~~ Annie M. Green

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker 088

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself Balto md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Jos Joh H. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Rebecca Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Mable Wheeler

(Address) 608 N. Monument St.

15 FEB 20 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1930, to Oct 18, 1930, that I last saw h[illegible] alive on Oct 17, 1930, and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis + mitral Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Dr Posey M. D.

10/18, 1930 (Address) 1424 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery DATE OF BURIAL Oct 20 1930

20 UNDERTAKER Chas. H. Johnson ADDRESS 716 N. Caroline St.

21

Spec.—1-30—M. & T.—250 Blks

E 61485 E 61485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (No. 17-24 ST. WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Dennis J. Lewis

(a) RESIDENCE NO. 1224 Argyle Ave. ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha

6 DATE OF BIRTH (month, day, and year): March 16, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Lancaster Co. Va.

PARENTS

10 NAME OF FATHER: Dennis Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Plina Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Records of Balto. City Hosp.

15 C. HAMPSON JONES, M. Registrar

OCT 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-17-30

17 I HEREBY CERTIFY, That I attended deceased from 3-31-30, 19..., to 10-17-30, 19..., that I last saw h... in life on 10-17-30, 19..., and that death occurred, on the date stated above, at 3:45 A. m.

The CAUSE OF DEATH* was as follows:

Hypertension, essential
(duration) More than 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage into cerebrum (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

10. 18. 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: Oct 20 30

20 UNDERTAKER: E. Hensley

ADDRESS: W. Balto St

Spec.—1-30—M. & T.—250 Bks

E 61486 HEALTH DEPARTMENT—CITY OF BALTIMORE 113 E 61486

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 19-28 WARD)

2-FULL NAME Frances Hauke

(a) RESIDENCE NO. 1838 Wilkens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6m yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5 1930.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4.	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Michael M. Hauke

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Christina Krimbolty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Michael M. Hauke

(Address)

Rec'd OCT 20 1930, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1930, to Oct 18th, 1930, that I last saw him alive on Oct 18th, 1930, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Gastro intestinal indigestion acute

Malnutrition Status Malicis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Nothing.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Only clinical data.

(Signed) S. J. Symm M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Moriah Hampden

DATE OF BURIAL Oct 20 1930

20 UNDERTAKER Shenowith Son

ADDRESS 340 Cathedral

Spec.—1-12-23—M&T—500 Bks.

E 61487

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61487

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 514 N. Rose St. 8-16

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., (WARD)

2-FULL NAME Robert Albert Hughes

(a) RESIDENCE NO. 514 N. Rose St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/14/1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Bruhn Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Nettie Amelia Cleland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant mother

(Address) 514 N. Rose St.

15 [illegible] 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1930, to Oct. 18, 1930, that I last saw him alive on Oct. 17, 1930, and that death occurred, on the date stated above, at 10:10 A. m.

The CAUSE OF DEATH* was as follows:

Premature delivery.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) L. C. Schlicht, M. D.

Oct. 19 30 (Address) 447 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Oct 20, 1930

20 UNDERTAKER John F Denny

ADDRESS 915 Light St

OCT 20 1930

TION is very important See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 61488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 61488

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 Aisquith ST., 9-18 WARD)

2-FULL NAME Mary D. Coleman

(a) RESIDENCE NO 1911 Aisquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 30/1930

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
		3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.,
(State or country)

PARENTS

10 NAME OF FATHER Thomas Coleman

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Agnes Coleman (mother)
(Address) 1911 Aisquith St

Filed 26 1930, 192 C. HARRISON JONES M. D. Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Broncopneumania

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) C. H. Kaelin, M. D.
Coroner

Oct 20/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pulaski Cemetery

DATE OF BURIAL 10-20 19 30

ADDRESS .....

UNDERTAKER George J. Puth Inc 1735 Madison

Spec.—I-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61489 | CERTIFICATE OF DEATH. | 129 E 61489

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 E. Preston ST., 9-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Dawson

(a) RESIDENCE NO. 720 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Thos. B. Dawson

6 DATE OF BIRTH (month, day, and year) Jan 5 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Margaret Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret E. Dawson (Address) 720 E. Preston St.

15 OCT 20 1930 19 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1930 to Oct 17 1930 that I last saw h[illegible] alive on Oct. 15 1930 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) a 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert E. Levy M. D.

10/19/30 (Address) 800 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Oct 21 1930

20 UNDERTAKER Rita Widefield

ADDRESS 914 Fremont Ave

Spec.—1-10-21 M&T 1500 Blks.

E 61490

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61490

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 3932 Park Heights Ave

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) 15-58

2-FULL NAME James Alexander Brooks

(a) RESIDENCE NO. 3932 Park Heights ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Virginia Brooks.

6 DATE OF BIRTH (month, day, and year) May 18 1870.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
60	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Builder

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Wm E Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from 1923 ....., 19....., to Oct 19 ....., 1930,

that I last saw h in alive on Oct 19 ....., 1930,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. H. D. Jones M. D. M. D.

, 19 (Address) 3912 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Maurice A Brooks

(Address) 34 Old court Rd Pikesville

15 Filed OCT 20 1930 C. HAMPSON JONES, M. D. Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Oct 22 1930

20 UNDERTAKER W M Routson

ADDRESS 2238 N Howard

CAUSE OF DEATH must be plainly written, and all blanks filled. See instructions on back of certificates. IMPORTANT is very important

1-30—M. & T.—100 B—50L

E 61491

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61491

CERTIFICATE OF DEATH

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 1-7 WARD)

2-FULL NAME Stephen W. Zamenski

(a) RESIDENCE NO. 45 S. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Zamenski

6 DATE OF BIRTH (month, day, and year) July 18-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist Helper
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer Standard Sanitary Mfg Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Zamenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Elizabeth Balcer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. T. Zamenski

(Address) 45 S. Stricker St.

15 Filed ..... 192 G. HAMPSON JONES, M. D. Registrar

T 20 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Generalized Peritonitis due to ruptured Small intestine Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Standard Sanitary Mfg Co. Oct 15 30

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D. Coroner

10-29, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL Oct. 22 1930

20 UNDERTAKER Stephen J. Trailbaum Jr. ADDRESS 1000 S. Kenwood Ave

Spec.—1-30—M. & T.—250 Bks.

61492 1
2417

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61492
159-001

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ St. 1-3 Ward)

2-FULL NAME Laurence Spedden

(a) RESIDENCE No. 2606 Fait Ave. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced, (write the word)~~
Male	White	Baby

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 6 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Spedden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 20 1930 C. 19 HAMPSON JONES, M. D.
(Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18th 30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1930, to Oct. 18, 1930, that I last saw him alive on Oct. 18, 1930, and that death occurred, on the date stated above, at 2-57 p.m.

The CAUSE OF DEATH* was as follows: Hydrocephalus. congenital communicative type

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Choroid plexectomy
Did an operation precede death? Yes Date of 10-18-30
Was there an autopsy? yes
What test confirmed diagnosis?

(Signed) Fred W. Fait, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL N. Hamilton Cem

DATE OF BURIAL Oct 20 19 30

20 UNDERTAKER Stephen J. Fialkowski

ADDRESS 1000 E. Monument

Spec.—1-30—M. & T.—250 Bks.

E 61493

E 61493

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-002

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD) 46-49

2-FULL NAME Mr. Lewis S. Wandell

(a) RESIDENCE NO. Wyman Park Apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mrs. Lewis Wandell

6 DATE OF BIRTH (month, day, and year) June 16, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52 yrs.	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Mr. Lewis Wandell

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y. City

12 MAIDEN NAME OF MOTHER Katherine Wandell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y. City

14 Informant Hospital records (Address)

15 Filed Oct 20 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12th, 1930, to Oct. 19th, 1930, that I last saw him alive on Oct. 19th, 1930, and that death occurred, on the date stated above, at 10:40 A m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(duration) 9 yrs.? mos ds.

CONTRIBUTORY (Secondary) Paralytic ileus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? yes Date of 10-16-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Samuel McClenahan, M. D.

Oct 19 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montrose New York

DATE OF BURIAL Oct 21 1930

20 UNDERTAKER Chas G. Black ADDRESS 742 W North ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 61494

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61494

CERTIFICATE OF DEATH

REGISTERED NO. 3 1 V

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 Penna Ave ST. 5-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Palmer

(a) RESIDENCE NO. 1308 Penna Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: 0

6 DATE OF BIRTH (month, day, and year): July 4, 1906

7 AGE: 24 Years | Months 3 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Waiter

(c) Name of employer: N.C.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Tomus Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Manie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Ellie Harris

(Address): 607 W Lanvale St

15 Filed 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Oct 17, 1930.

That I last saw h[illegible] alive on Oct 17, 1930

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of 0

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) John C Sprout, M. D.

Oct 20 1930 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon

DATE OF BURIAL: 10 20 1930

20 UNDERTAKER: Frank D Saunders

ADDRESS: 1308 Penna Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 61495 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 61495

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5522 Summerfield Ave. WARD 27-43)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fanny Weament

(a) RESIDENCE NO. 5522 Summerfield Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Weament

6 DATE OF BIRTH (month, day, and year) 3-6-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Adam Wheam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Wheam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Katherine Livingstar

(Address) 5522 Summerfield Ave

15 [illegible] 19

C. HAMPSON JONES, Registrar

OCT 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 30

17 I HEREBY CERTIFY, That I attended deceased from August 24 1930, to Oct 18th 1930, that I last saw h[illegible] alive on Oct 18th 1930 and that death occurred, on the date stated above, at 6:54 p. m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis, aortic regurgitation of heart

(duration) yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) General anasarca

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) C. Tony Weibel M. D.

10/20, 1930 (Address) 1124 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL Oct 22 1930

20 UNDERTAKER J. J. Rench

ADDRESS 640 S Eutaw

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 61496

2416 E 61496

HEALTH DEPARTMENT—CITY OF BALTIMORE

135

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 14-54 WARD)

2-FULL NAME John Winder

(a) RESIDENCE No. 2200 Mc Culloh ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	W Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jennie Winder

6 DATE OF BIRTH (month, day, and year) ? 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 20 1930 19 _____ Registrar C. HAMPSON JONES M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct- 17, 1930, to Oct 17, 1930, that I last saw him alive on Oct- 17, 1930, and that death occurred, on the date stated above, at 7 50 a. m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy and obstruction

(duration) 1 yrs. _____ mos _____ ds.

CONTRIBUTORY (Secondary) Uremia

(duration) _____ yrs. _____ mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of _____

Was there an autopsy? no—

What test confirmed diagnosis? Blood urea 1.64 mgm

(Signed) Conrad Acton, M.D. M. D.

10-17, 1930 (Address) Hopkins Hospital—

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Oct. 20 1930

20 UNDERTAKER Mrs Geo. H. Holland

ADDRESS 1631 Druid Hill

TION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 61497

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61497

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) En route to University Hospital (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antone Millar

(a) RESIDENCE No. Michigan Ave. (St.) Balto. Highlands (Ward) Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Miller

6 DATE OF BIRTH (month, day, and year) May 31 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Schuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Marie Meckel (Daughter)

(Address) Michigan Ave-Balto. Highlands.

15 Filed 20 1930 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Miller M. D.
Coroner

10/17 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Co.

DATE OF BURIAL Oct 21 1930

20 UNDERTAKER Fred R. Poe

ADDRESS 1200 W. Lombard

Spec.—1-10-21—M&T—1500 Bks.

E 61498 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61498

CERTIFICATE OF DEATH.

REGISTERED NO. 159

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2220 Sidney ave St. 25-32 WARD

2-FULL NAME Joseph LeRoy Kraft

(a) RESIDENCE NO. 2220 Sidney ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Louis B. Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine E Read

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Louis B Kraft 2220 Sidney Ave.

15 OCT 20 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18 1930

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to Oct. 18, 1930, that I last saw him alive on 10-18, 1930 and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale - aortic regurgitation (since birth)

(duration) 7 yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic arthritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & clinical signs

(Signed) James Brown M. D.

, 19 (Address) 705 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Oct 21 1930

20 UNDERTAKER Joseph Dyer

ADDRESS 1400 N North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 61499 HEALTH DEPARTMENT—CITY OF BALTIMORE. 162 ✓ E 61499

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. Sinai Hospital ST. 610 WARD)

2-FULL NAME Baby Girl Klotzman

(a) RESIDENCE NO. 5 N. Gillington Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS
10 NAME OF FATHER Benj. Klotzman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Lillian Diamond
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Benj. Record
(Address) .....

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar
OCT 20 1930
By .....

TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20. 1930

17 I HEREBY CERTIFY, That I attended deceased from October 20, 1930, to October 20, 1930, that I last saw ... alive on October 20, 1930, and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:
Atelectasis (asphyxia)

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Charles Robert Cohen, M. D.
, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Grove Wash Road — DATE OF BURIAL 10-20 19 30

20 UNDERTAKER Pace Heirs; 1439 — ADDRESS Wals. St

Spec.—1-30—M. & T.—250 Bks

E 61500

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61500

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH Baltimore City Hospitals T.B. 6-4
CITY OF BALTIMORE: (NO. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Travers

(a) RESIDENCE NO. 211 N. Bond st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Harold Travers
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Lizzie Travers
11 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 C. HAMPSON JONES, M. D. Registrar
By ..... 19 .....

20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 19 29, to Oct. 12, 19 30, that I last saw him alive on Oct. 12, 19 30, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jewett, M. D.

10-13-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

UNIVERSITY OF MARYLAND
OCT 20 1930

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61501

CERTIFICATE OF DEATH

161-001

E 61501

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 Hoffman ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Mack

(a) RESIDENCE NO. 302 E. Hoffman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Elijah Mack

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Serena Evans

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant

(Address)

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

201930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19-30

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity

3 mo.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Whitridge, M. D.

19 (Address) 102 E. Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
Commissioner of Health
OCT 20 1930

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61502

CERTIFICATE OF DEATH.

E 61502

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1134 W. Pratt ST. 18 29 WARD)

2-FULL NAME Baby Haggard

(a) RESIDENCE NO. 1134 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15 30

7 AGE Years Months Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1134 W. Pratt

PARENTS

10 NAME OF FATHER W. L. Haggard

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Emelia Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wurtzburg

14 Informant Mother, Emelia Haggard

(Address) UNIVERSITY OF MARYLAND

15 OCT 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1930, to Oct 18, 1930, that I last saw h[illegible] alive on Oct. 17, 1930, and that death occurred, on the date stated above, at about 10 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

Immature youth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hagen, M. D.

, 19 (Address) 216 Harrow

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OCT 20 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 61503 E 61503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 McCulloh St. 11-24 WARD)

2-FULL NAME Lillie Giles

(a) RESIDENCE NO. 1119 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Alonzo Giles

6 DATE OF BIRTH (month, day, and year) 3/29/1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ornaments

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer Mrs Giles

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER John Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Chavis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Parker

(Address) 1119 McCulloh St

15 Filed OCT 20 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16-1930

17 I HEREBY CERTIFY, That I attended deceased from 10/10/30, to 10/17/30, that I last saw h alive on 10/16/30 and that death occurred, on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Gr. Lobar

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Kidney trouble

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Lee Chin M. D.

10/20/1930 (Address) 92 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

24 1283
24 61504

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61504

44

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME Harry Johnson

(a) RESIDENCE NO. 524 N. Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charlotte

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lubricating R-R

(b) General nature of industry, business, or establishment in which employed (or employer) Engineering

(c) Name of employer R R

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Julia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Friends (Address)

15 Filed OCT 20 1930, 19 C. HAMPSON JONES, M. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13. 30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1930, to Oct. 13, 1930, that I last saw him alive on Oct. 13, 1930, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

Secondary anemia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis C. N. S. Meningo Paresis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Benj. M. Baker, Jr. M. D.

Oct. 14 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL OCT 20 1930 19

ADDRESS

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

JOHNS HOPKINS HOSPITAL

Commissioner of Health

Spec.—1-30—M. & T.—250 Bks. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 61505

24612
Ped.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61505

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Stanley

(a) RESIDENCE NO. 422 No. Central Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. moe. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 ~~Single, Married, Widowed,~~ or ~~Divorced,~~ (write the word)

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1930

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosetta Hollins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed OCT 20 1930, 19

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Oct 15, 1930,

that I last saw him alive on Oct- 15, 1930,

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? History & Physical findings

(Signed) J. C. Goodwin M. D.

10/15, 19 30 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL OCT 20 1930, 19

20 UNDERTAKER

ADDRESS

C. Hampson Jones, M. D. Commissioner Health

How to fill out this certificate. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 61506

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61506

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Perry

(a) RESIDENCE NO. 1606 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beatrice

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 623

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer E.T. Foreman

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed Oct 26 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18-30

17 I HEREBY CERTIFY, That I attended deceased from 10-2-30, 19..., to 10-18-30, 19...

that I last saw him alive on 10-18-30, 19...

and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, without oedema.

(duration) yrs. 3½ mos. da.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 9 da.

18 Where was disease contracted if not at place of death? 1. Hospital 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Paul Padget, M. D.

10-IX. 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Oct. 21, 1930

20 UNDERTAKER Mrs. R. G. Ellicott — ADDRESS 1705 Eastern Ave.

Spec.—1-30—M. & T.—250 Blks. Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 61507 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61507

101-009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 15-21 ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Slade

(a) RESIDENCE NO. 1640 N. Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Williamston

(State or country) N.C.

PARENTS

10 NAME OF FATHER Horace Slade

11 BIRTHPLACE OF FATHER (city or town) N.C.

(State or country)

12 MAIDEN NAME OF MOTHER Hannah Price

13 BIRTHPLACE OF MOTHER (city or town) N.C.

(State or country)

14 Records of

Informant

(Address) Balto. City Hosp.

15 Filed OCT 20 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18-30

17 I HEREBY CERTIFY, That I attended deceased from 10-16-30, 19, to 10-18-30, 19, that I last saw him alive on 10-18-30, 19, and that death occurred, on the date stated above, at 3:40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical & am. culture

(Signed) Paul Padgett, M. D.

10-19-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson N. C.

DATE OF BURIAL Oct. 20, 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1726 Washington Ave

Instructions for filling out this certificate. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

(James F. Ronig)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 ✓

E 61508

E 61508

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Mem. Hosp. Ward) 12-51

2-FULL NAME Jos F. Ronig

(a) RESIDENCE NO. 2032 W. 29th St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth P. Ronig

6 DATE OF BIRTH (month, day, and year) Jan 13-1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	9	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wrapper
(b) General nature of industry, business, or establishment in which employed (or employer) Tailoring
(c) Name of employer do

9 BIRTHPLACE (city or town)
(State or country) Pa

PARENTS

10 NAME OF FATHER Jacob Ronig

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Eddinger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Ruth P. Ronig
(Address) 2032 W. 29th St.

OCT 20 1930

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & knocked down by moving auto at intersection
(a)
(b)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Union Mem Hosp

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Thein M. D.

10/18 1930 (Address) 20 W Eday

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Oct 21 1930.

20 UNDERTAKER Mrs. John N. Teufel & Son — ADDRESS 801 W. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61509 — 90 E 61509

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) 1339 N. Stricker ST. 15-22 (WARD)

2-FULL NAME Susie Jones

(a) RESIDENCE NO. 1339 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21 22	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rasburry, Va.

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Florena Brown (Address) 1339 N. Stricker St

15 19 C. HAMPSON JONES, M. D. Registrar

20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10- 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-7- 1930, to 10-10- 1930, that I last saw h[illegible] alive on 10-14- 1930, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease

Personal knowledge 1 wk

History (duration) yrs. mos 6 wks. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George A. Page M. D.

19 (Address) 816 N. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond, Va. DATE OF BURIAL: 10/20 19 30

20 UNDERTAKER: Thomas E. Nelson ADDRESS: 1303 Overbrook Av

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61510

CERTIFICATE OF DEATH.

E 61510

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1814 Mc Henry St. St. 14-26 Ward)

2-FULL NAME Andrew Rethmann

(a) RESIDENCE NO. 1814 Mc Henry St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Mary E. Rethmann

6 DATE OF BIRTH (month, day, and year): Sept 17, 1864

7 AGE: Years 66 | Months 1 | Days 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Office clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Steel Company

(c) Name of employer: Carnegie Steel Co

9 BIRTHPLACE (city or town): [illegible]

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Herman Rethmann

11 BIRTHPLACE OF FATHER (city or town): [illegible]

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Magdelene Rethmann

13 BIRTHPLACE OF MOTHER (city or town): [illegible]

(State or country): Unknown

14 Informant: Mrs. Walter S. McCain.

(Address): 1814 Mc Henry St

15 Filed: C. HAMPSON JONES, M. D.

Registrar

201930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: October 19th. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1930, to Oct. 19, 1930, that I last saw h[illegible] alive on October 18th, 1930, and that death occurred, on the date stated above, at 5.00 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary): Cancer of Stomach & Liver

(duration) yrs. 2 mos. ds.

18 Where was disease contracted? —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None necessary.

(Signed) Harry E. Bates, M. D.

19 (Address) 1523 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial Oct 21 19 30

20 UNDERTAKER: Harry A Wilkes ADDRESS: 101 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61511

90 ✓

REGISTERED NO. E 61511

1-PLACE OF DEATH Homestead Apartments
City of Baltimore: (No. St. Paul & 31st Sts. St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Gilbert Farren

(a) RESIDENCE NO. St. Paul & 31st Sts. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Burdette H. Farren

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	76			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Cincinnati,
(State or country) Ohio

PARENTS

10 NAME OF FATHER --- Gilbert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) ----

12 MAIDEN NAME OF MOTHER ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) ------

14 Informant William H. Jennings
(Address) 1704 First Nat. Bank Bldg.

15 OCT 26 1930 19 H. MASON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 192 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows:
Coronary Thrombosis
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Hosmer M. D.

Oct 20, 1930 (Address) 7622 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct. 21, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Place

Mathew Mitchell

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61512 + 49 E 61512

CERTIFICATE OF DEATH

REGISTERED NO. 11158

1—PLACE OF DEATH U.S. Marine Hospital #1 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (N Oak St + Wyman Park Drive 1st WARD) 51

2—FULL NAME Albert H. Bridges

(a) RESIDENCE NO. St. Michaels, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Divorced

6a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Nora Bridges

6 DATE OF BIRTH (month, day, and year) June 30, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	3	19 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman (First Mate)

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. 086

(c) Name of employer S.S. Albert C. Ritchie

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas F. Bridges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Deborah E. Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

204 1930 ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1930, to Oct 20, 1930, that I last saw him alive on Oct 20, 1930 and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of right lung

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St. Michaels, Md.

Did an operation precede death? No Date of

Was there an autopsy? Yes (Chest + abdomen)

What test confirmed diagnosis? Autopsy

(Signed) Gordon A. Abbott, M. D.

, 19 (Address) U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Michaels Md — DATE OF BURIAL Oct 21 1930

20 UNDERTAKER John O. Mitchell & Son — ADDRESS 1911 Eutaw Place

Spec.—1-30—M. & T.—250 Bks.

E 61513 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61513

31

CERTIFICATE OF DEATH.

REGISTERED NO. ____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 751 Eastview Av ST., 8-45 WARD)

2-FULL NAME Mildred D. Horschele

(a) RESIDENCE NO. 751 Eastview Av ST., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ da. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Herman Horschele

6 DATE OF BIRTH (month, day, and year) Sept 15th 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	34	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md

PARENTS

10 NAME OF FATHER Frank E. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md

12 MAIDEN NAME OF MOTHER Barbara Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore. Md

14 Informant Herman Horschele
(Address) 751 Eastview Av

Filed ____ 19 ____ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19th/30

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1926 to Oct 19, 1930, that I last saw her alive on October 19, 1930, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. 7 mos 13 ds.

CONTRIBUTORY (Secondary) Acute Myelogenous Leukaemia (duration) ____ yrs. 1 mos. 29 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ____

Was there an autopsy? No What test confirmed diagnosis? Physical Examination Examination of Blood

(Signed) Albert Greenberg M. D.

10/20 1930 (Address) 2025 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 21st 1930
UNDERTAKER	ADDRESS
L. B. Wippert	1850 W. Baltimore St

Spec.—1-10-21—MAT—1500 Blks.

E 61514

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61514

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital (No. 70 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD

2-FULL NAME Esther Dixon.

(a) RESIDENCE NO. 3204 Frederick Ave (If non-resident give city or town and State)

(Usual place of abode) How long in U. S., if of foreign birth? yrs. mos. ds.

Length of residence in city or town where death occurred 1 yrs. 8 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 3rd 1929

7 AGE: Years 1 Months 8 Days 15 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED: —

(a) Trade, profession or particular kind of work: —

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Thomas A Dixon

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Arnold A Bizel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant Thomas A. Dixon (Address) 3204 Frederick Ave

Registrar C. HIMPSON JONES, M. D.

DATE 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1930, to Oct 18, 1930, that I last saw her alive on Oct 18, 1930 and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows: Lobar Pulmonia Rt.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Toxemia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Hilmer S. Anderson, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Oct 21st 1930

20 UNDERTAKER F. B. Wehrheit ADDRESS 1850 W. Baltimore

TION is very important See instructions on back of certificates. Exact statement of OCCUPA-

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61515 179 E 61515

REGISTERED NO. 43-32

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital. Ward)

2-FULL NAME Henry F.Dammann.

(a) RESIDENCE NO. 13 W.Barney St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married.

5a If married, XXXXXXXXXXX
HUSBAND of XXXXXXXX Ruby E.Dammann.

6 DATE OF BIRTH (month, day, and year) December 20,1896

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33	9	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rigger,
(b) General nature of industry, business, or establishment in which employed (or employer) Consolidated Gas
(c) Name of employer and Electric Co.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis R.Dammann.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Louisa Bonner.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Ruby E.Dammann.(wife)
(Address) 13 W.Barney St.

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

Oct 20 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 18,1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burns about the body and Limbs.
Igniting of rubbing Alcohol
Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 18 W. Barney st. October 1b, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Eyrhardt, M. D.

10/20 19 30 (Address) 1017 S.Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 10/21 1930

20 UNDERTAKER William Cook — ADDRESS 127 S Paca St

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-30—M. & T.—250 Bks.

Dr Jones 1011 S Ellwood

E 61516

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61516

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 S. Curley ST., 1-1 WARD)

2-FULL NAME Louis F. Kraisser

(a) RESIDENCE NO. 1006 S Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Alice E Kraisser

6 DATE OF BIRTH (month, day, and year) June 20, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stockster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick Kraisser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lizzie Smatz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alice E Kraisser (Address) 1006 S Curley St

15 Filed ..... 19 ..... H. LINCOLN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4th, 1930, to Oct. 20th, 1930, that I last saw him alive on Oct. 19th, 1930, and that death occurred, on the date stated above, at 9 A, m.

The CAUSE OF DEATH* was as follows:

acute septic meningitis

(duration) ..... yrs. ..... mos 11 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ..... yrs. 25 mos. 15 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) David D Stone, M. D.

10/20/1930 (Address) 1011 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenmore Cem

DATE OF BURIAL 10/23 1930

20 UNDERTAKER W. Cook

ADDRESS 1217 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61517

CERTIFICATE OF DEATH.

74 9 E 61517

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sir Lewis S. Sinclair Apt 418 ST. WARD)

2-FULL NAME Henry Clay Fowler.

(a) RESIDENCE NO. 1205-E Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jane

6 DATE OF BIRTH (month, day, and year) Oct 1 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	91	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Evan Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Wash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Howard A. Bartol

(Address) 1205-E Baltimore.

15 Filed OCT 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Oct 19, 1930, that I last saw him alive on Oct 19, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. A. Bessemer, M. D.

10-19-1930 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Faulston Md. DATE OF BURIAL Oct. 22 1930

20 UNDERTAKER William Cook ADDRESS 1217 St Paul

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

Dr Robinson Med Arts Bldg.

E 61518 **HEALTH DEPARTMENT—CITY OF BALTIMORE** C 61518

101-04

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 St Paul ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Coyle Thuber

(a) RESIDENCE NO. 1809 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Charles G. Thuber

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary E Gill

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Julia R Mathews

(Address) 2095 Lafayette Ave

15 Filed OCT 20 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1930, to Oct. 20, 1930, that I last saw her alive on Oct. 20, 1930, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical symptoms —

(Signed) A. F Robinson, M. D.

Oct 20, 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 10/22 1930

20 UNDERTAKER J M Cook

ADDRESS 1218 Park St

Spec.—2-29-28—L. F. S.—500 Blks.

E 61519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

48 E 61519

1—PLACE OF DEATH

REGISTERED NO. 12-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland Gen Hosp ST., 12-44 WARD)

2—FULL NAME Mrs Linda Muench

(a) RESIDENCE NO. 216 Chauncey Rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of — Herman Muench

6 DATE OF BIRTH (month, day, and year) July 4, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairmont West Virginia

PARENTS

10 NAME OF FATHER Elias Shelton

11 BIRTHPLACE OF FATHER (city or town) Fairmont (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Isabella Lanham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital records
(Address)

15 Filed 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 19 30, to Oct. 19, 19 30, that I last saw h.. alive on Oct. 19, 19 30 and that death occurred, on the date stated above, at 4:25 P. m.

The CAUSE OF DEATH* was as follows:

Squamous cell epithelioma of cervix with metastasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis to bowel

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of July 2 1928

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) Robert V. Clements, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 10/22 1930

20 UNDERTAKER Wilson Cook

ADDRESS 1217 St Paul St

8pec.—1-30—M. & T.—250 Bks

E 61520

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61520

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 1927 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geneva Johns

(a) RESIDENCE NO. 26 N. Norris ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hezekian

6 DATE OF BIRTH (month, day, and year) Jan. 4 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER George Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Braddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Records of

(Address) Balto. City Hospitals

Filed 2-1-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17-30

17 I HEREBY CERTIFY, That I attended deceased from 6-14-30, 19, to 10-17-30, 19,

that I last saw h er alive on 10-17-30, 19,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease

more than 1 yrs. mos ds.
(duration)

CONTRIBUTORY (Secondary) Myocarditis. acute, Rheumatic (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? [illegible] 2. hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

10-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn

DATE OF BURIAL Oct 21 1930

20 UNDERTAKER Franklin W Seitz

ADDRESS 709 W 33d St

Spec.—1-30—M. & T.—250 Bks

CAINE

E 61521 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61521

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST. 92-30 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Caine

(a) RESIDENCE NO. 526 W. Barre ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored.	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Maggie Caine

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Cambridge Md.

PARENTS

10 NAME OF FATHER John Caine.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosie Manly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records O.

(Address) BALTIMORE CITY HOSPITALS

15 Filed OCT 21 1930 HANS P. JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1930, to Oct 18, 1930, that I last saw him alive on Oct. 18, 1930, and that death occurred, on the date stated above, at 11:59 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Auricular f. by. Illation

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No Yes

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Padget. M. D.

10-19 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-21 1930
20 UNDERTAKER Kemp's Eastern	ADDRESS 916 Cross

Spec.—1-30—M. & T.—250 Bks.

E 61522

E 61522

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No.) 1514 Division ST. 18 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Curtis

(a) RESIDENCE NO. 818 Sarah Ino ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Maggie Curtis

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Friend.
(Address)

15 [illegible] C. RAMPSON JONES, M. D.
Registrar

16 [illegible] 19 [illegible]

T 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19/30

17 I HEREBY CERTIFY, That I attended deceased from 10/17, 1930, to 10/18, 1930, that I last saw him alive on 10/19, 1930, and that death occurred, on the date stated above, at 12 40/A m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension (cardio vascular)

(duration) 2 yrs 11 months and

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George W. Donald M. D.

, 19 (Address) Provident Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	10-21 1930
20 UNDERTAKER	ADDRESS 916
Daniel Coston,	2 W

Spec.—1-30—M. & T.—250 Bks.

E 61523

E 61523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. North Broadway ST. 12-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HANSON, Mary E.

(a) RESIDENCE NO. 104 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ford B. Hanson

6 DATE OF BIRTH (month, day, and year) Mar. 5, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	7	13	

8 OCCUPATION OF DECEASED None.

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Wakeland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Wakeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. M. H. Arbuckle

(Address) 104 W. North Ave.

15 Filed OCT 21 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 4th, 1930, to October 18, 1930, that I last saw her alive on October 18th, 1930, and that death occurred, on the date stated above, at 10:20 p.m.

The CAUSE OF DEATH* was as follows:

Uraemia

24 hours

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) Years yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 17, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical observation.

(Signed) Oscar E. Hubbard, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Churchville, Md	Oct 21, 1930
20 UNDERTAKER E. LeRoy Stiffler, INC	ADDRESS 125 E. North Ave.

Spec.—2-29-28—I. F. S.—500 Bks.

E 61524 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61524

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 117

CITY OF BALTIMORE: (No. Domenica Maggio ST. 1-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mamie Micceli

(a) RESIDENCE NO. 3411 Greenmount Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Micceli

6 DATE OF BIRTH (month, day, and year) April 1st 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Phillip Maggio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Maggio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant John Micceli

(Address) 3411 Greenmount ave

15 C. HAMPSON JONES, M. D. Registrar

OCT 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-30

17 I HEREBY CERTIFY, That I attended deceased from 10-7, 1930, to 10-20, 1930, that I last saw h[illegible] alive on 10-20, 1930 and that death occurred, on the date stated above, at 5 55 A m.

The CAUSE OF DEATH* was as follows:

General peritonitis
Following appendectomy and
Hysterectomy

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-9-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. W. Plake M. D.

. 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Oct 23 1930

20 UNDERTAKER Frank V. Pipitone — ADDRESS 2818 E. Balto st

Spec.—1-30—M. & T.—250 Bks.

E 61525

E 61535
240535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

153

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Cole

(a) RESIDENCE NO. 702 N Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Royal

6 DATE OF BIRTH (month, day, and year) Feb-20-1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Selby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Wilhemina Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 21 1930 C. HAMPSON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept-9, 1930, to Oct-20, 1930, that I last saw h[illegible] alive on Oct 20, 1930, and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

entire abdominal abscess

Pulmonary embolism

[illegible] (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical confirmed at operation

(Signed) J A Abercrombie, M. D.

, 19 (Address) J H Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery

DATE OF BURIAL 10/23/30

20 UNDERTAKER T. E. Williams

ADDRESS 1515 N. Eden St

Spec.—1-30—M. & T.—250 Bks

E 61526

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61526

44 ✓

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Glendale ST. 27 WARD) 27-43

2-FULL NAME Barney Brenner

(a) RESIDENCE NO. 3107 Glendale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Brenner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Frida —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis (Address) 1439 E Baltimore St.

15 Filed OCT 21 1930 C. HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Oct 20, 1930, that I last saw him alive on Oct 20, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Anaemia & Toxaemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach with metastases

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Biopsy

(Signed) Claus Smuck, M. D.

Oct 20 1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodmen Circle Memorial Park Carroll DATE OF BURIAL 10-21- 1930

20 UNDERTAKER Jacob Louis ADDRESS 1439 E Baltimore St.

E 61527

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61527

CERTIFICATE OF DEATH.

31

REGISTERED NO. 1943

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) 3709 Marmony Ave ST. 18-29 WARD

2-FULL NAME Mrs Rene Sentz

(a) RESIDENCE. No. 1014 Hollins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

3a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of C. J. Sentz

6 DATE OF BIRTH (month, day, and year) Dec 23, 1903

7 AGE: Years 27 | Months 10 mos | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Clarence Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Mary E Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Mary E Murray 1014 Hollins St

15 Oct 21 1930 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 19 30, to , 19 , that I last saw her alive on Oct 20, 19 30, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis and heart failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr G. A. Bachus, M. D.

, 19 (Address) 1023 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: Dec 23 1930

20 UNDERTAKER: Emmert & Sons

ADDRESS: 360 Whitelock Ave

OCT 21 1930

THIS IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

61528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 61528

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3237 Phelps Lane ST. 20-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise M. Browne

(a) RESIDENCE NO. 3237 Phelps Lane ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank A. Browne

6 DATE OF BIRTH (month, day, and year) June 1, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Muirkirk
(State or country) Maryland

PARENTS

10 NAME OF FATHER Mark B. Duvall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) Beltsville
(State or country) Maryland

14 Informant Mr. Samuel S. Browne

(Address) 3237 Phelps Lane

Filed OCT 21 1930 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10. 1930. to Oct 19. 1930.

that I last saw her alive on Oct 19. 1930

and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows*

Bright's Kidney disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular heart disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) C. C. Hearn M. D.

Oct 20 1930 (Address) 3901 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct. 22 1930

UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Blks.

E 61529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 61529

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1829 Eagle ST. 14-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina Hofmann.

(a) RESIDENCE NO. 1829 Eagle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Chas Hofmann

6 DATE OF BIRTH (month, day, and year): Dec 27 1859

7 AGE: Years 70 | Months 9 | Days 23 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John. Galm.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Cath. Hess

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Chas. Hofmann.

(Address) 1829 Eagle St.

Filed OCT 21 1930 By E. C. HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Oct 19, 1930, that I last saw her alive on Oct 19, 1930, and that death occurred, on the date stated above, at 12 55 A m.

The CAUSE OF DEATH*, was as follows: Hemiplegia. Chronic Valvular Heart Disease (Mitral Stenosis) Chronic Nephritis "Angina Pectoris"

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Clinical

(Signed) A. Kelly Hemming M. D.

10/21/1930 (Address) 7000 Hollins Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer.

DATE OF BURIAL: 10-22 1930

UNDERTAKER: E. & B. Harlow

ADDRESS: 115 E West St

Cor.—10-10-29—A Co.—100 Bks.

E 61530

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61530

CERTIFICATE OF DEATH

V 170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1300 Light St. St. 23-33 (Ward)

2-FULL NAME Robert M. Brinegar.

(a) RESIDENCE NO. 1300 Light St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of ~~wife of~~ Lucy Brinegar.

6 DATE OF BIRTH (month, day, and year) January 7, 1906

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	24	9	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): West Virginia.
(State or country)

PARENTS

10 NAME OF FATHER: Lorenza Brinegar.

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Ida McComas.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Ohio.

14 Informant: Kenneth Brinegar. (brother)
(Address): 1300 Light St.

OCT 21 1930

C. HARRISON JONES, M.D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 18, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
Pistol sht wound through the heart Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry.

(Signed) Otto M. Bernhardt, M. D.

10/21, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Hamlin W. Va.	10-21 1930
UNDERTAKER: Bernard C. Hartz	ADDRESS: 1000 S Paca St

IMPORTANT. See instructions on back of certificate. DEATHS to be plainly written, and no part of any word or property classified. Each question must be answered.

Spec.—1-30—M. & T.—250 Bks.

Z 40148
Z 61531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5/ E 61531

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 16-23 WARD)

2-FULL NAME Norman B. Hallows

(a) RESIDENCE NO. 1211 W. Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 11 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ppb

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S. Car

PARENTS

10 NAME OF FATHER Rufus

11 BIRTHPLACE OF FATHER (city or town) (State or country) S Car

12 MAIDEN NAME OF MOTHER Texas Samples

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S Car

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 21 1930 C. HAMPSON JONES, Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-19-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1930, to Oct 19, 1930, that I last saw him alive on Oct 19, 1930, and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:

Rheumatic Carditis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Rheumatic Carditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. C. Goodwin, M. D.

10/22 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Oct 22, 1930

20 UNDERTAKER Estie R. Williams

ADDRESS 322 N Schroeder St.

Spec.—1-30—M. & T.—250 Bks

E 61532 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61532

CERTIFICATE OF DEATH. 31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 W Lee ST., 22-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Essie Brown

(a) RESIDENCE NO. 604 W Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Major Brown

6 DATE OF BIRTH (month, day, and year) Feb 12 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator in Oyster

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster Packing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Corn Hill S. Carolina

PARENTS

10 NAME OF FATHER John W Cathers

11 BIRTHPLACE OF FATHER (city or town) Corn Hill (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Peter Nash

13 BIRTHPLACE OF MOTHER (city or town) Corn Hill (State or country) S. Carolina

14 Informant Major Brown (Address) 604 W Lee

15 Filed OCT 21 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Oct 18, 1930, that I last saw her alive on Oct, 18, 1930, and that death occurred, on the date stated above, at 11 9, m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 1 yrs. 11 mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Universal Dispensary

(Signed) Dan Drancken, M. D.

10/21/1930 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL Oct 21, 1930

ADDRESS 3224 Schroeder St

20 UNDERTAKER Mrs Katie R. Williams

1-30—M. & T.—100 B—50L

E 61533

HEALTH DEPARTMENT—CITY OF BALTIMORE

97 E 61533

CERTIFICATE OF DEATH

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) En route to University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Young

(a) RESIDENCE No 322 N. Poppleton ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Young

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Shorter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. A. Cooper

(Address) Gloucester, Va.

Filed Oct 21 1930 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Revolver wound of chest

Homicide (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 657 W. Lexington St

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Eugene Zellers Coroner, M. D.

10/20 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Co. Va

DATE OF BURIAL Oct 21, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

John M Treuleb

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 61534

E 61534

CERTIFICATE OF DEATH

REGISTERED NO. 21-34

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1180 Washington Blvd (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John. Michael Treuleb

(a) RESIDENCE NO. 1180 Washington Blvd WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Treuleb

6 DATE OF BIRTH (month, day, and year) Oct 13 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Treuleb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabeth Treuleb

(Address) 1180 Washington Blvd

15 Filed ..... 19 ..... Registrar C. HARRISON JONES, M. D.

OCT 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1927, to Oct 21, 1930.

that I last saw h[illegible] alive on Oct 20 19[illegible]

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Signs

(Signed) Jas L. Hooper, M. D.

10/24, 1930 (Address) 3462 28 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Oct 23 1930

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2173 Pa

Spec.—1-30—M. & T.—250 Bks.

E 61535

E 61535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) South Baltimore Gen Hospital (St., WARD) Eagle Ridge
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary [redacted] Ridge

(a) RESIDENCE NO. 1103 Olive ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 29 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced (HUSBAND of or) WIFE of: Wm Ridge

6 DATE OF BIRTH (month, day, and year): March 31/1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework at home
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Charles H. Miller
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md
12 MAIDEN NAME OF MOTHER: Leola Buckman
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 INFORMANT (Address): Mrs Lillie Miller (Mother) 1526 Light st

15 FILED: OCT 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-19-30

17 I HEREBY CERTIFY, That I attended deceased from 10-18, 1930, to 10-19, 1930, that I last saw her alive on 10-19, 1930, and that death occurred, on the date stated above, at 3.10 p.m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Ruptured Appendix (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 10-18-30
Was there an autopsy? no
What test confirmed diagnosis? Physical Findings
(Signed) Joseph S. Kaufatis, M. D.
(Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 22 1930

20 UNDERTAKER: John F Denny — ADDRESS: 915 Light St

Spec.—1-30—M. & T.—250 Bks

E 61536 HEALTH DEPARTMENT—CITY OF BALTIMORE 118-002 E 61536

CERTIFICATE OF DEATH

70-69

1-PLACE OF DEATH University Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) Lombard & Green ST., WARD)

2-FULL NAME Paul Palachansky

(a) RESIDENCE NO. 323 S. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1914

7 AGE 16 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Stief. Palachausky

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russian

12 MAIDEN NAME OF MOTHER Dora Vaselevska

13 BIRTHPLACE OF MOTHER (city or town) Russian
(State or country)

14 Informant Stief Palachausky
(Address) 323 S. Smallwood St.

15 FILED 19 By C. HAMILTON JONES, M. D.
Registrar

2 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct, 20, 1930, to Oct, 20, 1930, that I last saw h[illegible] alive on Oct, 20, 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction
Mesenteric Thrombosis
Generalized Peritonitis
(duration) yrs. mos 7 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Oct, 20, 1930

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George W. Yeager M. D.

10/20, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Russian Independent DATE OF BURIAL Oct. 23. 1930

20 UNDERTAKER John Greblinuckas ADDRESS 425 S Paca St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61537

E 61537

CERTIFICATE OF DEATH

REGISTERED NO. 117

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital ST., (WARD) 46-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Casper Sellmayer

(a) RESIDENCE NO. 521 S. Conkling ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine E. Sellmayer

6 DATE OF BIRTH (month, day, and year) Jan 14 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	9	14	

8 OCCUPATION OF DECEASED Sellmayer

(a) Trade, profession or particular kind of work Meat Packing Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Pres + Treas

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Ludwig Sellmayer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Dora Winkeler

13 BIRTHPLACE OF MOTHER (city or town) Balto Co.
(State or country)

14 Informant Catherine E. Sellmayer
(Address) 521 S. Conkling St.

15 Filed 21 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 30, to Oct 18, 1930, that I last saw him alive on Oct 18, 1930, and that death occurred, on the date stated above, at 5:05 P.m.

The CAUSE OF DEATH* was as follows:

Cholecystitis, Chronic &
Cholelithiasis
Appendicitis, Chronic.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Oct 13, 1930

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Operative

(Signed) Chas D. Stiles Jr M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

None

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Oct 22 1930

20 UNDERTAKER E. Eilly + Guilarme. — ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks.

61538 E 61538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital St. 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Gomeringer

(a) RESIDENCE NO. Stemmers Run, Maylene ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Late Frederick W. Gomeringer

6 DATE OF BIRTH (month, day, and year) July 8th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Colyton	70	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Johann Wolfgang Gomeringer

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Walburga Ertl.

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Rose M. Stanley (Daughter)

(Address) Back River Neck Road Balto Co.

15 Filed OCT 24 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1930, to Oct. 20th, 1930, that I last saw h... alive on October 20, th, 1930, and that death occurred, on the date stated above, at 7:50 P. m.

The CAUSE OF DEATH* was as follows:

Incarcerated Umbilical Hernia

Hepatic Obstruction

Myocardial Degeneration - Auricular Fibrillation

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Acute Gastric Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) C. H. Jones M. D.

, 19 (Address) 2 E Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Oct. 23 1930

20 UNDERTAKER Fallon Zeller

ADDRESS 1407 W Mt St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61539

161-001 ✓

E 61539

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3220 Belvidere ave ST. 27-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Unnamed Infant (Julius Walter Davis)

(a) RESIDENCE NO. 3220 Belvidere ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred few hrs yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 20th 1930

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
few hrs	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jos S Davis

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Ruby C Strabler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Joseph L. Davis
(Address) 3220 Belvidere Ave.

15 Filed OCT 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Oct 20, 1930

that I last saw h— alive on Oct 20, 1930

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of heart

(duration) few hrs yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth, 7th Month

(duration) few hrs yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) C. B. Turner, M. D.

Oct 21, 1930 (Address) 1926 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Oct. 21, 1930

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 900 Eutaw Pl.

Spec.—1-30—M. & T.—250 Bks.

E 61540 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61540

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Leo Rascovar

(a) RESIDENCE NO. 2304 Wichita Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of or) WIFE of Sadie Rascovar

6 DATE OF BIRTH (month, day, and year) Dec 28 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburgh, Pa.

PARENTS

10 NAME OF FATHER Robt. Rascovar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Tillie Friedman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. L. Rascovar

(Address) 2304 Wichita Ave

FILED OCT 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to ~~Sept~~ Oct 20, 1930, that I last saw him alive on Oct 19, 1930, and that death occurred, on the date stated above, at 4 15 A m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix, generalized peritonitis, abdominal abscess, general asthenia, 2° anemia, cardiac failure.

(duration) yrs. 5 mos 6 ds.

CONTRIBUTORY (Secondary) abdominal abscess

(duration) yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death? 2304 Wichita Ave

Did an operation precede death? Yes Date of Oct 3/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hugo Kuhn Bayless, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 10/21/1930

20 UNDERTAKER Harris Sonnenstein Sons

ADDRESS 1902 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61541 — 90 — E 61541

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 409 Robert ST. 14-20 WARD)

2—FULL NAME Henrietta Robolbt

(a) RESIDENCE NO. 409 Robert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced, HUSBAND of (or) WIFE of: Albert G. Robolbt.

6 DATE OF BIRTH (month, day, and year): July 28, 1861

7 AGE — Years: 69 — Months: 7 — Days: 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wishen Gray.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Isabell Gentleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Husband

(Address): 409 Robert St.

15 2 1 1930 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1930, to Oct 21 30, that I last saw h[illegible] alive on Oct 20 1930 and that death occurred, on the date stated above, at 355 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arterio - Sclerosis

about (duration) 1 yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George McDonald, M. D.

, 19 (Address) 900 N. Franklin St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Oct. 24, 1930

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1631 Dru

Spec.—2-22-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61542

CERTIFICATE OF DEATH

101-001 ✓ E 61542

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Westwood ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morgan Haynie

(a) RESIDENCE NO. 1717 Westwood Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced: HUSBAND of (or) WIFE of Effie Haynie

6 DATE OF BIRTH (month, day, and year): ? 1893

7 AGE: Years 37; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Peter Haynie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Emma Kemper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Willard Haynie
(Address): 700 W. Lafayette Ave

15 Filed: OCT 21 1930 19 C. HAMPTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Oct 21, 1930, that I last saw h/ m/ alive on Oct 21, 1930 and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George McDonald M. D.

19 (Address) 900 N. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northumberland Co Va

DATE OF BURIAL: Oct 24/30

UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1631 Druid Hill Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61543

CERTIFICATE OF DEATH

129 E 61543

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST. 13-52 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Randall

(a) RESIDENCE NO. + Home for Incurables ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 10-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER ? Randall

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) unknown

12 MAIDEN NAME OF MOTHER Maria Tuly

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country) unknown

14 Informant Mrs. Geo. DeTown.
(Address) Victory Pavilion + Lombard St.

15 Filed OCT 21 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 30

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921 to Oct 20, 1930
that I last saw her alive on Oct 20, 1930
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical methods

(Signed) W. B. Mayo M. D.

10/21, 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Oct 23 1930

20 UNDERTAKER Hughes & Hirschmann

ADDRESS 1101 Broadway

Spec.—1-30—M. & T.—250 Bks.

E 61544 E 61544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph Hospital REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Edmondson Ave (St., Ward) 24B

2-FULL NAME Anna Kohl

(a) RESIDENCE NO. 522 N Rose ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23, 1886

7 AGE — Years: 43 — Months: 11 — Days: 29 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS
10 NAME OF FATHER Otto Herpel
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER Emma Schultz
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jos Kohl
(Address) 522 Rose St.

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-30

17 I HEREBY CERTIFY, That I attended deceased from 10-15-30, 19....., to 10-20-30, 19.....,
that I last saw h alive on 10-20-30, 19.....,
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia Secondary Cancer of the Stomach
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis Hemorrhage
(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Course
(Signed) W. E. Kendrick, M. D.
, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from: Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer
DATE OF BURIAL: 10/23 1930

20 UNDERTAKER: Jos A Early
ADDRESS 1900 W Fayette

Spec.—1-30—M. & T.—250 Bks.

E 61545

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61545

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Baltimore City Hospitals ST. 26-37 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Annie M. Dill

(a) RESIDENCE (Usual place of abode) NO 3735 Eastern Ave ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edgar N. Dill

6 DATE OF BIRTH (month, day, and year) Feb 12 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	8 7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Meat Packing

(c) Name of employer Lehmayer Bros Packing Co.

9 BIRTHPLACE (City or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wright Evans ?

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant
(Address) Baltimore City Hospitals

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19-30

17 I HEREBY CERTIFY, That I attended deceased from 8-4-30, 19.., to 10-19-, 1930, that I last saw h.. alive on 10-19-, 30, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with Jaundice Abdominal Metastasis

(duration) unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? yes Date of 9-5-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings

(Signed) Fred M. Outerbridge, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Oct 22 1930
20 UNDERTAKER	ADDRESS
M. W. E. Dappel Inc	37 Lexington

21 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 61546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-09 E 61546

REGISTERED NO.

1—PLACE OF DEATH 2110 D Hill ave

CITY OF BALTIMORE: (No. Balto Md ST. 14-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Lovena Carter

(a) RESIDENCE NO. 2110 D Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	—	11	

11 ds

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: St Paul Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Inez Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant

(Address)

15 OCT 21 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/20/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1930, to Oct 20, 1930

that I last saw h[illegible] alive on Oct 19, 1930

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows: Premature Birth

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary): Hemophilia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J R Fellas, M. D.

19 (Address) 1512 Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: OCT 21 1930 19

20 UNDERTAKER

ADDRESS

E 61547

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61547

CERTIFICATE OF DEATH.

185

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5502 Morello Road. ST. 27-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Friedmann

(Residence in Baltimore: No. 5502 Morello Road. St. 56 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Husband John Friedmann Jr

Sept. (Month) 19 (Day), 1874 (Year)

7-AGE, 56 yrs. 1 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frederick Gross.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Strauss

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Son

(Address) 5502 Morello Road

15- Filed OCT 21 1930 16- RPH Registrar. H. EMMETT JONES M.D.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19 (Month) (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Fractured left hip. Accidently fel in yard. At home.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Coller M. D.
(Coroner)

Oct 21/30, 191... (Address) 108 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs.....mos.....ds. In the State ....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Loudon Park.	Oct 24 1930

20-UNDERTAKER Thos Owen Sutton & Son ADDRESS 101 N. Eutaw St.

Important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 61548

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 61548

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 767 W. Lexington ST. 12-51 WARD)

2-FULL NAME Lula Ruse

(a) RESIDENCE NO. 427 W. 24th ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Ruse 1867

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Wm. E. Ruse

(Address) 959 Rosedale St.

15 C. HAMPSON JONES, M. D. Registrar

OCT 21 1930 By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zellers, M. D. Coroner

10/20, 1930 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Oct 22 1930

20 UNDERTAKER Harry W. Ebling

ADDRESS 946 Mountain

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61549 | 117 E 61549

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH U.S. Marine Hospital Baltimore, Md.

CITY OF BALTIMORE: (No. 14-30 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Wise

(a) RESIDENCE NO. 1909 Druid Hill Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

2a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Wise

6 DATE OF BIRTH (month, day, and year): Nov. 15, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	34	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Head Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): Seaman

(c) Name of employer: SS Virginia

9 BIRTHPLACE (city or town) (State or country): Norfolk Virginia

PARENTS

10 NAME OF FATHER: Thomas Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk, Va.

12 MAIDEN NAME OF MOTHER: P. Saber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norfolk, Va.

14 Informant: Records, U.S. Marine Hospital

(Address): Baltimore, Maryland

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 16, 1930, to October 21, 1930,

that I last saw him alive on October 21, 1930

and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Appendicitis, acute, suppurative, gangrenous

(duration) ....yrs....mos. 7 ds.

CONTRIBUTORY (Secondary) Peritonitis, acute, general

(duration) ....yrs....mos. 4 ds.

18 Where was disease contracted if not at place of death? aboard ship

Did an operation precede death? yes Date of Oct.16,1930

Was there an autopsy? Examination & Operation

What test confirmed diagnosis?

(Signed) [signature], M. D.

10/31, 1930 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Oct. 23, 1930

20 UNDERTAKER: E. Leroy Stiffler, Inc.

ADDRESS: 126 E. North Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

E 61550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-006 E 61550

REGISTERED NO. 12-51

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 W. North Avenue ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Arbuckle

(a) RESIDENCE NO. 104 W. North Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie Hanson Arbuckle

6 DATE OF BIRTH (month, day, and year) November 20, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER William Arbuckle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotoland

12 MAIDEN NAME OF MOTHER Elizabeth Arbuckle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Daniel Arbuckle

(Address) 104 W. North Ave.

15 Filed 21 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 19th, 1930, to Oct 21st, 1930.

that I last saw him alive on Oct 20th, 1930

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1903 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Churchville, Md

DATE OF BURIAL Oct 22, 1930

20 UNDERTAKER E. LeRoy Stiffler, Inc

ADDRESS 1256 N. North Ave

Spec.—1-30—M. & T.—250 Bks.

E 61551 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61551

CERTIFICATE OF DEATH. X 92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Drane

(a) RESIDENCE NO. Chase, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: John Drane

6 DATE OF BIRTH (month, day, and year): July 11 1855

7 AGE: Years 55 Months 3 Days 9 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: August Light

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Adalon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: John Drane

(Address) Chase Md

15 [illegible] 1930

16 [illegible] 19 WILLIAMSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930, to Oct 19, 1930, that I last saw h[illegible] alive on Oct 19, 1930, and that death occurred, on the date stated above, at 4:05 p.m.

The CAUSE OF DEATH* was as follows:

Enterocolitis, generalized

Coronary thrombosis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton B Crook, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: 10/22/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 E Fayette St

Spec.—I-30—M. & T.—250 Bks.

E 61552

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61552

CERTIFICATE OF DEATH.

49

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5902 York Road ST. 27-45 WARD

2-FULL NAME Robert Bennett Price

(a) RESIDENCE NO. 5902 York Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Coleman

6 DATE OF BIRTH (month, day, and year) May 5, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 286

(b) General nature of industry, business, or establishment in which employed (or employer) Bath Paper Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thos. C. Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Dyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thos. Price (Address) 5902 York Rd.

15 Filed 21 1930 19 Per ..... Registrar

16 H. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to Oct-20, 1930, that I last saw h in alive on Oct-20, 1930, and that death occurred, on the date stated above, at 2-20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum, metastasis to liver and intestines.

(Duration) 1 yrs. 5 mos 20 ds.

CONTRIBUTORY (Secondary) Osteo-arthritis of hands

(Duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. Hampson Jones, M. D.

10/21, 1930 (Address) 4842 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 10/22 1930

20 UNDERTAKER C. J. Fleming & Son

ADDRESS 1938 Lafayette Ave.

Spec.—1-30—M. & T.—250 Bks.

E 61553

E 61553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

241313 Surg. X 123

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Otis Wingo

(a) RESIDENCE NO. Kensan Capts., Wash. D.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced,~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. Otis Wingo

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
53	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Congressman

(b) General nature of industry, business, or establishment in which employed (or employer) Govt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10 NAME OF FATHER Theodore Wingo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Jane Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D. Registrar

OCT 22 1930 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1930, to Oct 21, 1930, that I last saw h.i.m alive on Oct 21, 1930, and that death occurred, on the date stated above, at 1032 P.m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis and Common Duct Stone

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Post Operative Shock

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes. Date of Oct 20, 1930

Was there an autopsy? No (Removal of Stone)

What test confirmed diagnosis? Operation

(Signed) Rawley M. Pemick Jr. M. D.

, 19 (Address) Johns Hopkins Hospital Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C.

DATE OF BURIAL Oct. 22 1930

UNDERTAKER Martin W. Bysong & Co

ADDRESS 1305 N. Cap St. N.W.

Spec.—8-16-29—L. F. S.—100 Bks.

E 61554

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 61554

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 267 S. Bond St. ST., 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mike Konarski

(a) RESIDENCE NO. 267 S. Bond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Magdalena Konarski

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Magdalena Konarski

(Address) 267 S. Bond St.

15 Filed , 19 C. HAMPSON JONES, Registrar

OCT 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20, 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 30 to Oct 20, 30

that I last saw him alive on Oct 20, 30

and that death occurred, on the date stated above, at 11. A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dyspnea

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

Oct 21 1930 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL Oct. 23 1930

20 UNDERTAKER F. H. Grazewski

ADDRESS 1930 Eastern Ave

Spec.—1-30—M. & T.—250 Bks.

E 21555 E 21707

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 61555

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 17-24 WARD)

2-FULL NAME WILLIAM Henry Halliday

(a) RESIDENCE NO. 1222 Argyle ST., WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Maggie

6 DATE OF BIRTH (month, day, and year) 8-14-52

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work butler

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19-30

17 I HEREBY CERTIFY, That I attended deceased from 10-17-, 1930, to 10-19-, 1930,

that I last saw h~~im~~ alive on 10-19-, 1930,

and that death occurred, on the date stated above, at 3 20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Hypertension, Arteriosclerosis Myocardial degeneration (duration) 6 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1222 Argyle st

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Caroline C. Bedell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Oct 22, 30

20 UNDERTAKER John H. Trader

ADDRESS 1117 Druid Hill

22 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 61556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-001

REGISTERED NO. E 61556

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Tunis Lane ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kennard

(a) RESIDENCE NO. 105 Tunis Lane ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 14/30

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin C Kennard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lula V. Boyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Lola Kennard

(Address) 105 Tunis Lane

Filed Oct 22 1930, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Oct 21, 1930, that I last saw h alive on Oct 21, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Premature Built
7 mos

(duration) yrs. mos. ds.

CONTRIBUTORY Prematurity
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B Kennard M. D.

10/21, 1930 (Address) 714 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Oct. 22 1930
20 UNDERTAKER	ADDRESS
H W Cook	1217 E Pratt

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

61557 191 E 61557

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 18-26 WARD)

2-FULL NAME Edna Woodrew

(a) RESIDENCE No. 826 Cloney ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17 - ~~1901~~ 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32 ~~29~~	3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Attorney
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Blackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maggie Groscher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anna Robinson

(Address) 826 Cloney St.

15 Filed ..... 192 ..... Registrar

21930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to revolver wound of chest.

Homicide (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 783 Sarah Ann St

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene Feldes, M. D. Coroner

Oct 20, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt auburn

DATE OF BURIAL Oct 22nd 1930

20 UNDERTAKER A. Jones

ADDRESS 111 S Gilmor

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61558

CERTIFICATE OF DEATH.

12 VE 61558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1388 Stockton ST. 15-23 (WARD)

2-FULL NAME Chas. H. Rice

(a) RESIDENCE NO. 1388 Stockton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida S. Rice.

6 DATE OF BIRTH (month, day, and year) Feb 14. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) P. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Geo. Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Annie Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Ida S. Rice. (Address) 1388 Stockton St

Filed 10/22/1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/10, 1930, to 10/19, 1930, that I last saw h alive on 10/19, 1930 and that death occurred, on the date stated above, at 2:15 m

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
Chr. Nephritis

(duration) yrs. mos. 6 wks.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Rhutter, M. D.

10/22, 1930 (Address) 1174 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 10/22/1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

Spec.—8-16-29—L. F. S.—100 Bks.

E 61559 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 61559

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2327 Division ST. 19-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Holley

(a) RESIDENCE NO. 2327 Division ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
female	Colored	Yes

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER Frank Smothers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Florine Garner

(Address) 2327 Division St

15 [illegible] 22 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-30

17 I HEREBY CERTIFY, That I attended deceased from 8-8 ——, 1930 to 10-20, 1930 that I last saw her alive on 10-20 ——, 1930 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) — yrs. 2 mos. 12 ds.

18 Where was disease contracted if not at place of death? Balto. md

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) W Boykin, M. D.

, 19 (Address) 1512 Belmont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery

DATE OF BURIAL 10/22 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1302 Pierpont St

Cor.—10-10-29—A Co.—100 Bks.

E 61560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61560

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3706 Old Frederick Rd St., 20-71 Ward)

2-FULL NAME George W. Monk

(a) RESIDENCE NO. 3706 Old Frederick Rd. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. — mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie S. Monk

6 DATE OF BIRTH (month, day, and year) Oct 3, 1848.

7 AGE	Years	Months	Days	IF LESS than 1 day.... hrs. or .... min.
	82	—	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER George W. Monk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Susanna Ellis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Annie S. Monk
(Address) 3706 Old Falls Rd

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

T 22 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old Age

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brosius, M. D.

Oct 4, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn

DATE OF BURIAL Oct 23 19 30

20 UNDERTAKER H. A. Hupfeld

ADDRESS 5 S. Bond St.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 61561 E 61561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals (ST. 2-30 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME: Harry Britton

(a) RESIDENCE NO. 613 W. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Grace Britton

6 DATE OF BIRTH (month, day, and year): June 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundry work

(b) General nature of industry, business, or establishment in which employed (or employer): Ott

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Easton Pa.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Record of Balto. City Hosp.

15 10-27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-19-30

17 I HEREBY CERTIFY, That I attended deceased from 10-6-30, 19..., to 10-19-30, 19...,

that I last saw him alive on 10-19-30, 19...,

and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart Disease (duration) ...yrs. 10 mos ...ds.

CONTRIBUTORY (Secondary) Heart block, rheumatic (duration) ...yrs. ...mos. 2 ds.

18 Where was disease contracted if not at place of death? Home 2 Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Poorgt, M. D.

10-20, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Oct. 23, 30

20 UNDERTAKER: Jesse St. Ridden — ADDRESS 436 St. Biddle St

Rev—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61562

90 E 61562

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2709 Orleans St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Jones

(a) Residence No. 2709 Orleans St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Jones

6-DATE OF BIRTH (month, day and year) March 21 1870

7-AGE. 60 yrs. 6 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Last place Balto City
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS

10-NAME OF FATHER: James Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Alice Trautman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-(Informant) Charles W. Jones

(Address) 2709 Orleans St

15-Filed ..... 192 ..... C. HAMPSON JONES, M. D., Registrar.

221930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 20 30

I HEREBY CERTIFY, That I attended deceased from October 5 1930 to Oct 20 1930

that I last saw h[illegible] alive on Oct 20 1930

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Hypertension

(Duration) ..... yrs. ..... mos. ..... ds.

17-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John A. Silvernail M. D.

, 19 (Address) 1537 S Clark St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: Oct 23rd 1930

20-UNDERTAKER: Fred A. Kramer & Son — ADDRESS 703 Hanover

Spec.—2-29-28—L. F. S.—500 Bks.

E 61563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001 E 61563

REGISTERED NO. 1667

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Evans Brown

(a) RESIDENCE NO. 3315 Graymont Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Brown

6 DATE OF BIRTH (month, day, and year): Jan 8 1858

7 AGE: Years 72 | Months 9 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Evan Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wales

12 MAIDEN NAME OF MOTHER: Ann Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wales

14 Informant: daughter

(Address): 3315 Graymont Parkway

15 Filed OCT 22 1930 19 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 19 30, to Oct 20, 19 30

that I last saw h e alive on Oct 20, 19 30

and that death occurred, on the date stated above, at 6 30 p. m.

The CAUSE OF DEATH* was as follows:

Strangulated Ventral Hernia (Retroperitoneal)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Intestinal Invagination

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Oct 20

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) Robert L. Clemmitt M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery

DATE OF BURIAL: Oct 23 1930

20 UNDERTAKER: George W. Zirkler

ADDRESS: 1737 E. Eager st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61564

CERTIFICATE OF DEATH.

4th E 61564

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3822 Ridgecroft Rd ST., 27-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie May Grant

(a) RESIDENCE NO. 3822 Ridgecroft Rd ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 7.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George N. May Grant

6 DATE OF BIRTH (month, day, and year): May 3. 1864

7 AGE — Years: 66 — Months: 2 — Days: 16 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: William Hochgeboren

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mary Leichtweiser 3102 W Madison Ave

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar

T 221930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to Oct 19, 1930, that I last saw h[illegible] alive on Oct 19, 1930, and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Fisher M. D.

10/20/1930 (Address) 1823 N. Mad. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Oct 22 1930

20 UNDERTAKER: [illegible]

ADDRESS: 1600 W North Ave

TION IS very important. See instructions on back of certificates.

Spdc—12-25—M&T—500 Blks.

E 61565

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61565

38

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1044 Division ST., 17-24 WARD)

2-FULL NAME Katie Sherwood

(a) RESIDENCE NO. 1344 Division ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
31	"			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Philip Booze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Toney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lidia Toney
(Address) 1344 Division St.

15 Filed ... 19... C. HARRISON JONES, M. D. Registrar

T 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1930, to Oct 18, 1930, that I last saw h alive on Oct 18, 1930 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral (Hyph.) Lews
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Shelley, M. D.

Oct 20, 1930 (Address) 1720 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-22-1930

UNDERTAKER Dennis Eastern

ADDRESS 46 E Preston

Spec.—2-29-28—L. F. S.—500 Bks.

E 61566 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61566

1131

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 34-34

CITY OF BALTIMORE: (No.) 112 E Barney St (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J Feeley

(a) RESIDENCE NO. 112 E. Barney ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 12 1830

7 AGE — Years: 6 Months: 11 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Michael J Feeley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Christina Kelm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Michael J Feeley

(Address): 112 E Barney St

15 OCT 22 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1930 to Oct. 21, 1930

that I last saw him alive on Oct. 21, 1930

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. E. Campbell M. D.

10/21 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem.

DATE OF BURIAL: Oct. 23 1930

20 UNDERTAKER: Geo M Scully

ADDRESS: 128 E Fort Ave

Spec.—1-30—M. & T.—250 Bks.

E 61567

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61567

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 24-34 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Allen

(a) RESIDENCE NO. 1721 Light St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (HUSBAND) of or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Linen Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) ? dry goods

(c) Name of employer ?

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER August F. Weis ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Liza Mitzel ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Friends (Address) Baltimore City Hosp.

Filed OCT 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21-30

17 I HEREBY CERTIFY, That I attended deceased from 10-11-, 30, to 10-21-, 1930, that I last saw h[illegible] alive on 10-21-, 1930, and that death occurred, on the date stated above, at 12 30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus with local metastases

(duration) unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy finding

(Signed) Fred M. Olmsted M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gordon Park Cemetery DATE OF BURIAL Oct 23 1930

UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light St.

Spec.—1-12-23—M&T—500 Bks.

E 61568 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61568

47

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 Penrose Ave., ST., 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Myers

(a) RESIDENCE NO. 1918 Penrose Ave., ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Frederick Myers

6 DATE OF BIRTH (month, day, and year): Jan. 1876

7 AGE: Years 54 Months 9 Days ..... If LESS than 1 day, hrs. or..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James McHugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine Myers

(Address): 1918 Penrose Ave

Filed: OCT 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3rd., 1929, to Oct. 20th., 1930, that I last saw her alive on Oct. 20th., 1930, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Auto- Intoxication

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Pathological

(Signed) Edw Mendelsohn M. D.

10/22/1930 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Oct. 23 1930

20 UNDERTAKER: Margaret S. Flynn

ADDRESS: 1417 Light St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 61569 ✓ E 61569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 Harlem Ave ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby girl Floyd

(a) RESIDENCE NO. 904 Harlem Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edward James Floyd

11 BIRTHPLACE OF FATHER (city or town) Accomack
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Umbra E. Wicks

13 BIRTHPLACE OF MOTHER (city or town) Balt.
(State or country) Md.

14 Informant Umbra E. Floyd

(Address) 904 Harlem Ave

Filed OCT 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Oct 21, 1930, that I last saw h alive on Oct 20, 1930, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Lowry M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL Oct. 22, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N. Schroeder St

Spec.—1-30—M. & T.—250 Bks.

E 61570

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 E 61570

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 2-4 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Sactouris

(a) RESIDENCE NO. 711 S. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (1) HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Mattie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Records of Balto. City Hosp.

(Address)

15 Filed OCT 22 1930 HARRISON JONES M. E.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-30

17 I HEREBY CERTIFY, That I attended deceased from 6-2-30, 19.... to 10-20-30, 19....,

that I last saw h... alive on 10-20-30, 19....,

and that death occurred, on the date stated above, at 8:10 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. 4½ mos ds.

CONTRIBUTORY (Secondary) Myocarditis, acute

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically.

(Signed) Paul Padget M. D.

10-21, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL 10/23/30.

20 UNDERTAKER Woodlawn Co

ADDRESS 1730 Harford

Spec.—1-30—M. & T.—250 Bks.

E 61571 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61571

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2832 (St.) Clifton Ave (Ward) 5-60

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Gumpman

(a) RESIDENCE NO. 2832 (St.) Clifton Ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Chas. P. Gumpman

6 DATE OF BIRTH (month, day, and year) Sept 21 1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Chas. Merka

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Philip Gumpman (Address) 2832 Clifton ave

15 Filed OCT 22 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21st 1930

17

I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 21, 1930

that I last saw her alive on 18th Aug, 1930

and that death occurred, on the date stated above, at 12.35 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Malignant Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. E. Brumgardt M. D.

19 (Address) 101 Bayview Drive Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 10-24 1930

20 UNDERTAKER Bernard C Hahn — ADDRESS 1010 S Paca St

Spec.—1-30—M. & T.—250 Bks.

E 61572 E 61572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 28 Talbott St (If Brooklyn) ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David. H Lewis

(a) RESIDENCE NO. 28 Talbott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mattie Lewis

6 DATE OF BIRTH (month, day, and year) April 10

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Repairer

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) Winchester Va.

PARENTS

10 NAME OF FATHER Wm Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Not Known,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mattie Lewis

(Address) 28 Talbott St

15 Filed OCT 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20-30

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Oct 20, 1930, that I last saw h. alive on Oct 19, 30, and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

? (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Manuel De Wolfe M. D.

10/24 1930 (Address) 1331 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 10-23-30

20 UNDERTAKER E & B Harle 1152 E West St. — ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 61573

E 61573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Josephs Hosp. ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Brady

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8th 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank J. Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Elsie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs Elsie Smith Brady

(Address) 217 Dukeland St

15 C. HARRISON JONES, M. D.

Registrar

OCT 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 19 30, to Oct 20, 19 30,

that I last saw h alive on Oct 20, 19 30,

and that death occurred, on the date stated above, at 2:00 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Pneumonia Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical

(Signed) W H Chesley M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 10/24/30

UNDERTAKER Geo. Weber & Son - 2503

ADDRESS Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

E 61574 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61574

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 941 N. Sterling St. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Sherin

(a) RESIDENCE NO. 941 N. Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Single

5a If married, widowed, or divorced (HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Warren Sherin

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Johnnie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant John Sherin

(Address) 941 N. Sterling st

15 Filed 22 1930 19 C. H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18-30

17 I HEREBY CERTIFY, That I attended deceased from 10-11, 1930, to 10-18, 1930,

that I last saw h[illegible] alive on 10-18, 1930

and that death occurred, on the date stated above, at 4 P. m.,

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos 14 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. R. Blake M. D.

10/22/1930 (Address) 924 Fairmount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL 10-22 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1715 Eastland Ave Baltimore

1-30—M. & T.—100 B—50L

E 61575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 61575

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hopkins Hospital ST. 17-50 WARD)

2-FULL NAME Cora Hatchett

(a) RESIDENCE NO 324 E. 22i/2 St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Hatchett

6 DATE OF BIRTH (month, day, and year) June 14/1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	4	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Toney Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Bland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Thomas Jennings

(Address) 324 E 22 1/2 st

Filed OCT 22 1930 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pancreatotis

Thrombus of Splenic Vein

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [illegible], M. D. Coroner

Oct 19/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mt

DATE OF BURIAL Oct 27 1930

20 UNDERTAKER Mrs. R.G. Elliot

ADDRESS 1725 Ashland Ave

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61576 ✓ E 61576

101-001

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Back of 1513 Stricker ST. 15-21 WARD)

2—FULL NAME Thomas Morris

(a) RESIDENCE NO. 1513 Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1930

7 AGE — Years: — Months: 5 Days: 14 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Earl Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Howe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Earl Morris
(Address) 1513 Stricker St.

15 Filed 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/19/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 1930 to Oct 19 1930, that I last saw h[illegible] alive on Oct 19 1930 and that death occurred, on the date stated above, at 7 PM

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Colon (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1513 Stricker

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

19 (Address) 1513 Stricker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: Oct 22 1930

20 UNDERTAKER: H Mosley — ADDRESS: Baltimore

221930 C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 61577

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61577

CERTIFICATE OF DEATH.

REGISTERED NO. 51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3123 Lawnveiw Ave ST., 8-40 WARD)

2-FULL NAME Elizabeth B Euler

(a) RESIDENCE NO. 3123 Lawnveiw ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred 62 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of August J Euler or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS
10 NAME OF FATHER Henry Bartels
11 BIRTHPLACE OF FATHER (city or town) Ger
(State or country)
12 MAIDEN NAME OF MOTHER Elizabeth Wentzel
13 BIRTHPLACE OF MOTHER (city or town) Ger
(State or country)

14 Informant August J Euler
(Address) 3123 Lawnveiw Ave

15 221930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1930, to Oct 20, 1930, that I last saw h[illegible] alive on Oct 20, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam B Leuman, M. D.

10/21/1930 (Address) 718 N Pat Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Oct 23, 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

1-30—M. & T.—100 B—50L

E 61578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 61578

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 Argyle Ave. ST. 17-24 WARD)

2-FULL NAME Addie Mead

(a) RESIDENCE NO. 917 Argyle Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Mul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant A. W. United Police

(Address) Penna Ave

15 Filed ..... 192 C. HAMPSON JONES, M. D. Registrar

Per .....

22 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D. Coroner

Oct 20 1930 (Address) Barnes

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
Department of Legislative Reference
OCT 2 1990

1-30—M. & T.—100 B—50L

E 61579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-23 ✓ E 61579

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Mem Hosp ST. ..... WARD)

2-FULL NAME Chas. Smith

(a) RESIDENCE NO. Dont Know ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Not Known

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	About 45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd jobs
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Not Known

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant .....
(Address) .....

Filed 2-2 1930 192 C. HAMPSON JONES, M. D. Registrar
Par .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(A) Struck by motor auto (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract Skull (Duration) ..... yrs. ..... mos. ..... ds.

Fract Left Femur

18 Where was disease contracted if not at place of death? Not Known Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D. Coroner

10/22/30 Address 2989 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

ADDRESS Oct. 24/30

20 UNDERTAKER

THIS IS VERY IMPORTANT. See instructions on back of certificate.

UNIVERSITY OF MARYLAND

Cor.—10-10-29—A Co.—100 Bks.

E 61580

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 61580

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospl Ward) 26-37

2-FULL NAME Benjamin Gray

(a) RESIDENCE NO. Unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	about 40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed C. HAMPSON JONES, Registrar
OCT 22 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

(thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What (est confirmed diagnosis? Clinical

(Signed) James M Hinton, M. D.

10 22 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OCT 22 1930

Commissioner of Health

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61581 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61581

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 3-4 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wojciechowski

(a) RESIDENCE NO. 710 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Julia Wojciechowski

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - odd jobs

(b) General nature of industry, business, or estahlishment in which employed (or employer) odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 22 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-30

17 I HEREBY CERTIFY, That I attended deceased from 7-19-30, 19..., to 10-22-30, 19...

that I last saw him alive on 10-22-30, 19...

and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, arteriosclerotic

(duration) More than 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 1 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

10-22, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL Oct 24 1930

20 UNDERTAKER Peter M. Weber & Sons ADDRESS Charles

Spec.—1-30—M. & T.—250 Bks.

5523 ✓

E 61582

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61582

CERTIFICATE OF DEATH.

+ 90

5463

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4110 Penhurst Ave ST., ~~Livingston~~)

2-FULL NAME Rebekah G. Langsdale

(a) RESIDENCE NO. 4110 Penhurst Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 17 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Leslie

6 DATE OF BIRTH (month, day, and year) July 2 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Scruggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rebekah Gorsuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Rebecca Scruggs

(Address) 4110 Penhurst Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-11-, 1930, to 10-22-, 1930, that I last saw h[illegible] alive on 10-21-, 1930, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic - Chronic

Senile Inanition

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Wm. T. Howard, M. D.

, 19 (Address) 3523 Liberty Hts Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Md

DATE OF BURIAL Oct 22 1930

20 UNDERTAKER Wm Cole

ADDRESS 1217 St Paul

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61583 52 E 61583

CERTIFICATE OF DEATH

E 61583

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3110 Montebello Ave ST. (WARD) 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ann Tolloch

(a) RESIDENCE NO. 3110 Montebello Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Tolloch

6 DATE OF BIRTH (month, day, and year): Jan 11 1848

7 AGE: Years 82 | Months 9 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Eng Londo

PARENTS

10 NAME OF FATHER: [illegible] Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: [illegible] Duncan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Janet Tolloch

(Address) 3110 Montebello Ave

15 Filed 10/25/30 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 2/30, 19..., to Oct 22nd 19 30

that I last saw her alive on Oct 22nd 19 30

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) [illegible] M. D.

10/25/30 19 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Detroit, Mich.

DATE OF BURIAL: 10/23 1930

20 UNDERTAKER: [illegible]

ADDRESS: 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 61584 E 61584

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH U.S. Marine Hospital REGISTERED NO. 15-23

CITY OF BALTIMORE: (No. Baltimore, Md. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Solomon Lawson

(a) RESIDENCE NO. 1439 N. Carey St., Baltimore, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 24,1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A.B.Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Stephen W.McKeever,Jr.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jeremiah Lawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Bens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records, US Marine Hospital (Address) Baltimore, Md.

15 Filed 2 3 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 8, 19 30, to October 22, 19 30, that I last saw h 1m alive on October 22, 19 30 and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, interstitial

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia, acute

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) Gordon A. Abbott M. D.

10/22, 19 30 (Address) U.S.Marine Hospital, Balto., Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northumberland Co Lillian Po. Va

DATE OF BURIAL Oct 23 1930

UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61585 — 129 ✓ — E 61585

CERTIFICATE OF DEATH

1—PLACE OF DEATH: Dorchester Heights

CITY OF BALTIMORE (No.) 2608 (St.) Smith Ave (Ward) 25-B

REGISTERED NO. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: Frank Fleischman

(a) RESIDENCE NO. 2608 (Usual place of abode) St. Smith Ave Ward _____ (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lottie Fleischman

6 DATE OF BIRTH (month, day, and year): Dec 15 1861

7 AGE — Years: 68 — Months: 10 — Days: 6 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Piping Company

(c) Name of employer: _____

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Md

PARENTS

10 NAME OF FATHER: John Fleischman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Lottie Fleischman (Address) 2608 Smith Ave

15 Filed OCT 23 1930 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to Oct. 21, 1930, that I last saw him alive on Oct. 14, 1930, and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) — yrs. 5 mos. 11 ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) John A. Duchuess, M. D.

, 19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Oct 24 1930

20 UNDERTAKER: Gosposdens Son — ADDRESS: 2173 Pas

Spec.—1-30—M. & T.—250 Bks.

E 61586 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61586

74-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2716 W. Lombard ST. 20-6 WARD)

2-FULL NAME Florence E. Kerr.

(a) RESIDENCE NO. 2716 W. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Kerr

6 DATE OF BIRTH (month, day, and year) 9/10/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58.	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Magers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Kerr
(Address) 2716 W. Lombard

Filed OCT 23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22-1930

17 I HEREBY CERTIFY, That I attended deceased from 10/3 .1930. to 10/22 .1930.
that I last saw h alive on 10/22 .1930.
and that death occurred, on the date stated above, at 12 10 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy caused by hypertension

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 W. Lanvale Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Oct 24 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Pleasant

Spec.—1-30—M. & T.—250 Bks.

24 0838 24 61587

HEALTH DEPARTMENT—CITY OF BALTIMORE

VE 61587

84

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL) ST. 12-49 WARD)

2-FULL NAME Sally Spragg Morgan

(a) RESIDENCE NO. 5905 - Canterbury ST., Rd WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Wm H. Morgan

6 DATE OF BIRTH (month, day, and year) .....

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Penn -
(State or country)

PARENTS

10 NAME OF FATHER Geo. H. Spragg

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Smith

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Parents -
(Address) JOHNS HOPKINS HOSPITAL

Filed ..... 19 ..... Registrar

CT 231930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct - 21 - 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Oct 21, 1930, that I last saw her alive on Oct 21, 1930, and that death occurred, on the date stated above, at 9 25 a m.

The CAUSE OF DEATH* was as follows:

Intra cranial pressure probably due to tumor in brain or hemorrhage

(Duration) to date July 15 approx yrs. 3-4 mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency (duration) 8 yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes -

What test confirmed diagnosis? .....

(Signed) Ruth Graubard, M. D.

Oct 21 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Green Mount Cemetery	Oct 23 30.
20 UNDERTAKER Stewart Memorial Co	ADDRESS Balto

Spec. 7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

93 E 61588

E 61588

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1385 Whatcoat St. 15-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Ford.

(a) RESIDENCE NO. 1385 Whatcoat St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. • ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of John D. Ford.

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster Md.

(State or country)

PARENTS

10 NAME OF FATHER Joshua Paraway.

11 BIRTHPLACE OF FATHER (City or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

14 Informant James H. Smith

(Address) 1385 Whatcoat St

15 Filed OCT 23 1930 19 C. HAMPSON JONES, Registrar. By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October. 20/1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 13. 1930. to Oct. 20. 1930.

that I last saw her alive on October 19. 1930.

and that death occurred, on the date stated above, at 10.15 p. m.

The CAUSE OF DEATH* was as follows:

Septicaemia (see note on back)

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Varicose ulcers both limbs

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George L. Shannon M. D.

10/21. 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Oct-23 1930

20 UNDERTAKER Virginia A. Brooks ADDRESS 1463 W. Lanvale

very important. See instructions on back of certificates.

Spec.—2-29-28—1. F. S.—500 Bks.

E 61589

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ E 61589

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Colvin ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bettie Brown

(a) RESIDENCE NO. 108 Colvin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Brown

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 44 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): St. Marys Co. Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant: Andrew Brown

(Address) 108 Colvin St.

15 Filed ..., 19 ... Per ... Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 21-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1930, to Oct 21, 1930

that I last saw h... alive on Oct 21, 1930

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) Dan. Lloyd Berry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: Oct. 24 1930

UNDERTAKER: Chas. H. Johnson

ADDRESS: 446 N. Caroline St.

F 231930

1-30—M & T.—100 B—50L

E 61590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-002 ✓ E 61590

REGISTERED NO. .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 13-59 WARD)

2-FULL NAME Joseph Fedder

(a) RESIDENCE NO 724 Newington Ave., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Fedder

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Fedder (Son)

(Address) 724 Newington Ave.,

OCT 23 1930

C. HAMPSON JONES, M. D. Registrar

Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10- 22- 30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Car Accident

Multiple Fractures

(duration) yrs. mos 2 hrs.

CONTRIBUTORY (Secondary) Shock (duration) yrs. mos. 1 hrs.

18 Where was disease contracted if not at place of death? Newington & Galloway

Did an operation precede death? Date of -

Was there an autopsy? -

What test confirmed diagnosis? Ext

(Signed) [illegible], M. D. Coroner

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL B. Hebrew Wash. Road

DATE OF BURIAL 10-23- 19 30

20 UNDERTAKER Jack Levin, 1439 E Balto St

ADDRESS

IT IS very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 61591

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61591

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 21-24 WARD)

REGISTERED NO. 10100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Samuel Albery

(a) RESIDENCE NO. 1213 Bayard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Suffolk Va.

PARENTS

10 NAME OF FATHER: Israel Albery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Jane Brannick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Info. Records of Balto. City Hospitals

10-23-1930

15 Filed ..... 19 .....

H. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-19-30

17 I HEREBY CERTIFY, That I attended deceased from 7-3-30, 19..., to 10-19-30, 19...,

that I last saw him alive on 10-19-30, 19...,

and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary): Myocarditis, chronic.

(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? 1. Hospital 2. Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

10-24 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Oct 24, 1930

20 UNDERTAKER: Mrs Katie R Williams

ADDRESS 3229 Schroeder St

-30—M. & T.—100 B—50L

E 61592

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61592

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 21-24 (WARD)

2-FULL NAME Joseph Garrett.

(a) RESIDENCE NO. 811 Oslend ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Florence Garrett

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE: Years 49; Months; Days; If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Abbeville S.C.

PARENTS

10 NAME OF FATHER: Jos Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Abbeville S.C.

12 MAIDEN NAME OF MOTHER: Lettie Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Abbeville S.C.

14 Informant: Florence Garrett

(Address) 811 Oslend

CT 23 1930 Filed ..... C. HAMPSON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Ruptured Gastric Ulcer

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Leland Coroner, M. D.

(Address) Oct 23 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Oct. 23, 1930

20 UNDERTAKER: Mrs Katie R Williams

ADDRESS 322 N Broadway St.

Spec.—1-30—M. & T.—250 Bks

Wm. Ottoway Terry

E 61593 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61593

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Edmondson St. 17-23 WARD)

2-FULL NAME William Ottoway Terry

(a) RESIDENCE NO. 716 Edmondson St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Virginia Terry

6 DATE OF BIRTH (month, day, and year): Oct 15 1850

7 AGE — Years: 80 — Months: — Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Y.M.C.A.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Terry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Eliza Blackenburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Virginia Terry
(Address): 716 Edmondson Ave

T 23 1930 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1930, to Oct 21, 1930, that I last saw him alive on Oct 20, 1930, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) W. H. Lee Jr., M. D.

, 19 (Address) 1931 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

UNDERTAKER: Mrs. Katie R Williams

DATE OF BURIAL: Oct. 23, 1930

ADDRESS 3227 Schroeder St

Spec.—1-30—M. & T.—250 Bks

E 61594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

76 ✓ E 61594

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 6-11 ST.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Gager

(a) RESIDENCE NO. 151 N. Streeper St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) July 26, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk pt 9

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Gager

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Mary Redwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Records of Balto. City Hospitals

15 Filed OCT 23 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-30

17 I HEREBY CERTIFY, That I attended deceased from 6-25-28, 19.., to 10-20-30, 19.., that I last saw him alive on 10-20-30, 19.., and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of central Nervous System,

Tabo paresis (duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam: Wasserman.

(Signed) Paul Padget, M. D.

10-20 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Oct 23 1930

UNDERTAKER Geo. C. Miller & Son

ADDRESS 2334 Jefferson

Eugene [illegible] Mother — 2 brothers survive
Joseph Kedzierski
Life extinguished Monday Oct. 27 30.
E 61595 ✓ E 61595
J. Frederick Stumpel
asst. Com. of Health
94-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Aliceanna ST. 2-4 WARD)

2-FULL NAME Joseph Kedzierski

(a) RESIDENCE NO. 1912 Aliceanna ST. 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lucia Kedzierska

6 DATE OF BIRTH (month, day, and year) 3/15/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper 0/5

(b) General nature of industry, business, or establishment in which employed (or employer) Selling goods

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Swiadowo Poland

PARENTS

10 NAME OF FATHER Mike Kedzierski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Peter Kedzierski (Address) 1912 Aliceanna

15 [illegible] C. Hampton Jones M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-30 October 27 1930

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1930 to October 27, 1930, that I last saw him alive on October 21, 1930, and that death occurred, on the date stated above, at 12.10 p. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

1 Year (duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bronchitis

(Signed) H Sewalski, M. D.

10-28 1930 (Address) 1511 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery DATE OF BURIAL Oct 27 1930

20 UNDERTAKER George A Weber ADDRESS 708 S Ann St

OCT 23 1930

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61596

CERTIFICATE OF DEATH.

H+E 61596

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 737 McCabe Ave ST. 27-48 WARD)

2-FULL NAME Lewis Brown Collins

(a) RESIDENCE NO. 737 McCabe Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Briggs Collins

6 DATE OF BIRTH (month, day, and year) Oct 20-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Freight Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R.R. 07

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Warren Co - N.C.

PARENTS

10 NAME OF FATHER Lewis B. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C

12 MAIDEN NAME OF MOTHER Nancy Aycock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C

14 Informant Lewis B. Collins Jr.
(Address) 737 McCabe Ave

15 Filed OCT 23 1930. H. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1930, to Oct 21, 1930, that I last saw him alive on Oct 20, 1930, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma.

(duration) 4 mos yrs. — mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) MB Cummins Stone, M. D.

10/31, 1930 (Address) 2216 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Oct 23 1930

UNDERTAKER Cooley & Jones.

ADDRESS 1021 W Fayette

For —

ATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61597 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61597

113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-25 WARD)

2-FULL NAME Mary Marsiglia

(a) RESIDENCE NO. 610 w Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single.

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Marsiglia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Rose Cibrario

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr Charles Marsiglia

(Address) 610 w Baltimore St.

15 Filed , 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1930, to Oct 22nd, 1930, that I last saw her alive on Oct 22nd, 1930, and that death occurred, on the date stated above, at 10:45 p m.

The CAUSE OF DEATH* was as follows:

Premature delivery - Malnutrition.
Gastro intestinal indigestion.

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? Yes Date of -

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical findings.

(Signed) Chas E. Reid, M. D.

10/23 1930 (Address) University Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 10/25th/ 1930

20 UNDERTAKER John J Cowan & Son

ADDRESS 701 Hollins St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61598

E 61598

CERTIFICATE OF DEATH

27-3190

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 124 Hessman Court. St., ... Ward)

2-FULL NAME William C.Jordon.(C)

(a) RESIDENCE NO. 124 Hessman Court. St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Married

5a If married ~~widowed or divorced~~ HUSBAND of Mary Jordon.(C)
or WIFE of ~~XXXXXXXX~~

6 DATE OF BIRTH (month, day, and year) August 28,1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) St.Marys Co.Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Do not know.

14 Informant Helen Welsh.(C)
(Address) 829 Bevan St

Filed ..... 19 .....

C. HAMPSON JONES, M. D.
Registrar

OCT 23 1930

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22,1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Albert Reinhardt, M. D.

10/23 1930 (Address) 1017 E.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion C	Oct 25 1930
20 UNDERTAKER	ADDRESS
C. A. Brown & Son	Forest Glen

Spec.—1-30—M. & T.—250 Bks

E 61599 ✓ E 61599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hungerford Rd. ST., H-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Philip Englar

(a) RESIDENCE NO. Hunterstown Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos. da. How long in U. S., if of foreign birth? yrs mos da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M Englar

6 DATE OF BIRTH (month, day, and year) Aug 27 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68.	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired minister

(b) General nature of industry, business, or establishment in which employed (or employer) Gen

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Josiah Englar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susanna Ecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. W. P. Englar

(Address) Hunterstown Pa.

C. HAMPSON JONES, M.D. Registrar

CT 231930 File

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23/30

17 I HEREBY CERTIFY, That I attended deceased from 10-3, 1930, to 10-23, 1930, that I last saw h/m alive on 10-23, 1930, and that death occurred, on the date stated above, at 8:09 m.

The CAUSE OF DEATH* was as follows:

Cancer prostate Exhaustion

(duration) yrs. mos de.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Henry F. Schmit, M. D.

, 19 (Address) Univ. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pipe Creek Md

DATE OF BURIAL Oct 25 1930

20 UNDERTAKER H O Fuss & Son

ADDRESS Taneytown Md

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61600

E 61600

CERTIFICATE OF DEATH.

92

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 1521 Myrtle Av ST. 14-20 WARD)

2-FULL NAME Louisa Borris

(a) RESIDENCE NO. 1521 Myrtle Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Anthony Borris

6 DATE OF BIRTH (month, day, and year): Aug 12 1888

7 AGE: Years 42 | Months 2 | Days 5-6 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: William Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Sophia Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co

14 Informant (Address): Balto Town 1538 N Gay

15 Filed OCT 23 1930 MYRON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1930, to Oct 23, 1930, that I last saw h[illegible] alive on Oct 23, 1930, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Coronary occlusion

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Diabetes (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

, 1930 (Address) 1538 Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Oct 25 1930

UNDERTAKER: Marburn

ADDRESS: 700 N Carrollton Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61601

CERTIFICATE OF DEATH.

90 E 61601

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1035 Park Ave ST. 11-24 WARD)

2-FULL NAME David Flanagan

(a) RESIDENCE NO. 1035 Park Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Flanagan

6 DATE OF BIRTH (month, day, and year) January 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem

(c) Name of employer Steel Co.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER David Flanagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Martha Flanagan
(Address) 1035 Park Ave

15 Dec. C. HAMPSON JONES, M. D. Registrar

OCT 23 1930

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10, 22- 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1930, to Oct 22, 1930, that I last saw h— alive on Oct 19 30, and that death occurred, on the date stated above, at 12 midnight

The CAUSE OF DEATH* was as follows:

Endocarditis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism Dr Brown

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood

(Signed) J. D. Eglehart, M. D.

10,23 1930 (Address) 211 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Oct. 25, 1930
20 UNDERTAKER	ADDRESS
By Mrs. R. A. Elliott	1745 Ashland Ave

THIS is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 61602

E 61602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 26-37 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kestner

(a) RESIDENCE NO. North Point Rd., Colgate, Md. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Bruns

6 DATE OF BIRTH (month, day, and year) March 8, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York N.Y.

PARENTS

10 NAME OF FATHER Ignatious

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Records of

(Address) Balto. City Hosp.

Filed OCT 23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-30

17 I HEREBY CERTIFY, That I attended deceased from 10-15-30, 19..., to 10-22-30, 19..., that I last saw her alive on 10-22-30, 19..., and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic

(duration) UNKNOWN yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? In Hosp.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically.

(Signed) Paul Paget, M. D.

10-22, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel bmd

DATE OF BURIAL Oct 23 1930

UNDERTAKER J. J. Moran

ADDRESS 3000 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

E 61603 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61603

90

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 Barclay ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James F. Creagh

(a) RESIDENCE NO. 220 Barclay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cephalonia Creagh

6 DATE OF BIRTH (month, day, and year) 4-26-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	0	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Leonard Co. Washington D.C.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Peter Creagh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER M. A. Donnelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs J. Creagh

(Address) 220 Barclay St

Filed OCT 23 1930 G. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21-30

17 I HEREBY CERTIFY, That I attended deceased from July 1930 to Oct 21 1930,

that I last saw h alive on Oct 20 1930,

and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Paralytic Heart disease

(duration) 3 mos yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct 24 1930
20 UNDERTAKER Mary M. Medford	ADDRESS 501 E 22 St

Spec.—2-29-28—L. F. S.—500 Bks.

E 61604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 61604

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Gough ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MARGARET HOFFMAN

(a) RESIDENCE NO. 1304 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Hoffman

6 DATE OF BIRTH (month, day, and year) June 17, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	95	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Henry Walter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Kenler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss Carrie Walter (Sister)
(Address) 613 S. Hanover St. C. HAMPSON JONES

15 Filed OCT 23 1930 By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10th, 1930, to Oct. 22nd, 1930, that I last saw her alive on Oct. 20th, 1930 and that death occurred, on the date stated above, at 4.15 a.m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carl L. Hamm, M. D.

10-23 1930 (Address) 308 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. P.

DATE OF BURIAL Oct. 25, 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS 1800 BALTIMORE ST.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61605 E 61605

CERTIFICATE OF DEATH

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3240 Lewerton St. 26-2 Ward)

2-FULL NAME Eva M Beisler

(a) RESIDENCE NO. 3240 Lewerton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph G. Beisler

6 DATE OF BIRTH (month, day, and year) Oct 19 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60	0	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown Evans

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Joseph B Beisler
(Address) 3240 Lewerton St

15 Filed OCT 23 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
probably Interstitial

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

Oct 22 1930 (Address) 2002 Chas

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakdawn Cemetery

20 UNDERTAKER Henry Sander & Sons, Inc.

DATE OF BURIAL Oct. 25 1930

ADDRESS Baltimore St & Broadway

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. If DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

E 61606 ✓ E 61606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Lancaster ST., 3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME LOUISE SCHREIBER

(a) RESIDENCE NO. 1517 Lancaster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Schreiber

6 DATE OF BIRTH (month, day, and year) Jan. 3, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Siebert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Mr. Wm. Schreiber (Husband)

(Address) 1517 Lancaster Street.

Filed OCT 23 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 21st, 1930, that I last saw her alive on Oct 21, 1930 and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Uremia & Renal Cardio-Vascular Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) Louis Krause, M. D.

, 19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mount Carmel Cemetery — Oct. 25 19 30

20 UNDERTAKER — ADDRESS

Henry Sander & Sons. Inc. — Baltimore St & Broadway.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61607

185 E 61607

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospitals 23-33 WARD)

2-FULL NAME Elizabeth A. Ford

(a) RESIDENCE NO 23 E Henrietta ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Ford

6 DATE OF BIRTH (month, day, and year) Mar 15 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 037
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co Md

PARENTS

10 NAME OF FATHER George A Dowell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Francis B. Whitney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Pearl a. Dowell

(Address) 23 E Henrietta St

15 Filed ..... 192 H. M. SOLLERS, Registrar

RKM

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq mort (inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of Neck of Femur Fall down Stairs in Hos. Accident

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Taylor, M. D. Coroner

10/22/1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 10/25 1930

20 UNDERTAKER John A. Denny

ADDRESS 715 Light St

Spec.—1-30—M. & T.—250 Bks

E 61608 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61608

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Cor Lmd and Green ST. W-30 WARD)

2-FULL NAME Pickney Haines

(a) RESIDENCE NO. Watervillle Md ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moona Haines

6 DATE OF BIRTH (month, day, and year) Mar 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....m.
57		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Israel Haines

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ✓

...rmant University Hospital

...ress)

...1 C. HAMPSON JONES, Registrar

OCT 23 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1930, to Oct. 23, 1930, that I last saw h...alive on Oct. 23, 1930, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of Oct. 22-30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Yeager, M. D.

10/23, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Cemetery

DATE OF BURIAL Oct 26 1930.

ADDRESS

20 UNDERTAKER M. E. C. M. Watts Pittsfield Md.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61609 ✓ 90 E 61609

CERTIFICATE OF DEATH

REGISTERED NO. 18-29

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 910 Hollins ST., (WARD))

2—FULL NAME Mary Clara Hutchinson

(a) RESIDENCE NO. 910 Hollins ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced: HUSBAND of (or) WIFE of: John Hutchinson

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 61 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Francis J Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Hays

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John Hays
(Address) 910 Hollins st

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

2 31930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/21/30

17 I HEREBY CERTIFY, That I attended deceased from 2/10, 1929, to 10/21, 1930 that I last saw h[illegible] alive on 10/21, 1930 and that death occurred, on the date stated above, at 11:40 m.

The CAUSE OF DEATH* was as follows:
(a) Cardio-Renal
Myocarditis
Hypertension
(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary): Hypertension
(duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Warner, M. D.

10/22, 1930 (Address) Chas. & Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 10/24/1930

20 UNDERTAKER: Fogle Farley Fulton — ADDRESS: Fayette

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61610 E 61610

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3520 7th St. Brooklyn. St., 25-75 Ward)

2-FULL NAME Henry C. Kirchenbauer.

(a) RESIDENCE NO. 3520 7th St. Brooklyn. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed~~ or ~~divorced~~

HUSBAND of ~~XXXXXXXXX~~ Mary C. Kirchenbauer.

6 DATE OF BIRTH (month, day, and year) February 17, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	67	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) New Jersey.
(State or country)

PARENTS

10 NAME OF FATHER George M. Kirchenbauer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Lee.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Mary C. Kirchenbauer. (wife)
(Address) 3520 7th St. Brooklyn.

15 Filed ... C. HAMPSON JONES, M. D. Registrar
231930 By ... ARK

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 21, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Chas M Leonard M. D.

10/22 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 10/24/1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

Spec.—1-30—M. & T.—250 Bks.

Dr Heck-936 E Monument St

E 61611

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61611

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 E Hoffman ST., 9-18 WARD)

2-FULL NAME Albert George Barnett

(a) RESIDENCE NO. 1012 E Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Flossie Barnett

6 DATE OF BIRTH (month, day, and year) March 31.1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O RR.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Interment Mrs Flossie Barnett

(Address) 1012 E Hoffman St

Filed OCT 23 1930 HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22.1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1930, to Oct 22, 1930, that I last saw him alive on Oct 22 1930, and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe

(Chronic Intestinal Nephritis)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Albert G Heck M. D.

10/23 1930 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U S National Cem

DATE OF BURIAL 10/25 1930

20 UNDERTAKER H M Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

Dr Todd - Eastern Ave & 14th St

E 61612

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61612

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 S Streeper St., 1-1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.).

2-FULL NAME Howard L Walston Jr

(a) RESIDENCE No. 516 S Streeper St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22 1930

7 AGE — Years | 7 Months | 0 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Howard L Walston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Rupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Howard Walston

(Address) 516 S Streeper St

Filed Oct 23 1930, 19 ... Per ... Registrar

C. HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 20th, 19 30, to Oct 22d, 19 30,

that I last saw him alive on Oct 21st, 19 30,

and that death occurred, on the date stated above, at 1 20 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Todd M. D.

, 19 (Address) 4700 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 10/27 1930

20 UNDERTAKER E M Cook

ADDRESS 1217 E Fayette St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61613

88-103

E 61613

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hosp St. 4-25 Ward)

2-FULL NAME Pietro D'Amba

(a) RESIDENCE NO. 309 N. Green St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	M. Lower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosalia Frisella

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or ... min.
	89			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired gdl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Potatura
(State or country) Italy

PARENTS

10 NAME OF FATHER Giuseppe D'Amba

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Vincent D'Amba
(Address) 309 N Green St

15 Filed ... 19... C. HAMPSON JONES, Registrar.
By ...

231930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & knocked down by backing auto.

(a)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? in front of 309 Eutaw

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Frame M. D.

10 24 1930 (Address) 2939 Mt Olivet

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	10/27/30 19
20 UNDERTAKER Geo J Roth Inc	ADDRESS 1735 Hanover

important. See instructions on back of certificate.

E 61614

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61614

CERTIFICATE OF DEATH.

185

Registered No. C.....

1-PLACE OF DEATH: City of BALTIMORE: (No.) St. Joseph's Hos. (St.) 27-4 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: William Lafayette Williams

(Residence in Baltimore: No.) 5005 Alhambra Ave (St.) Yrs. 54 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: Oct (Month) 3 (Day) 1869 (Year)

7-AGE: 61 yrs. 0 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cashier Dept
(b) General nature of industry, business, or establishment in which employed (or employer): U.R.E.Co. Retired

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS

10-NAME OF FATHER: Charles C. Williams

11-BIRTHPLACE OF FATHER, (State or Country): Balto.

12-MAIDEN NAME OF MOTHER: Louise White

13-BIRTHPLACE OF MOTHER, (State or Country): Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Josephine Williams

(Address) 5005 Alhambra Ave

15-

OCT 24 1930

C. HAMPSON JONES, Registrar.

By .....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21/30 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base Skull—Accidently fell down stairway at his home Oct 17/30

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (Duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Falcer M. D.
(Coroner.)

Oct 23 192... (Address) 506 N North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Cem. DATE OF BURIAL. Oct 25, 19...

20-UNDERTAKER. Wm Tuckerman ADDRESS North St

1-30—M. & T.—100 B—50L

E 61615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002 E 61615

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST. 12-19 WARD)

2. FULL NAME Hannah Frey

(a) RESIDENCE NO 4246 E Federal ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas W.

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Wm W Crain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Jas W. Frey 4246 E Federal

(Address)

15 Filed ..... 192 C. HAMPSON JONES, Registrar

CT 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No By whom .....

What test confirmed diagnosis? .....

(Signed) H. Leslie Pyle, M. D. Coroner

(Address) 2nd Dist

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 10-25 1930

20 UNDERTAKER Geo L A Gilbert

ADDRESS 1735 Pennsylvania Ave

1-30—M. & T.—100 B—50L

E 61616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 61616

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enroute Hopkins Hospital ST. 1-3 WARD)

2-FULL NAME Felicks Puscian

(a) RESIDENCE NO 305 S. Duncan ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Puscian

6 DATE OF BIRTH (month, day, and year) May 25/1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Adam Puscian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anna Puscian
(Address) 305 S. Duncan St

OCT 24 1930

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Mathews, M. D. Coroner

Oct 23/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

UNDERTAKER Wazeleski

DATE OF BURIAL Oct 25 1930

ADDRESS 1939 Eastern

Spec.—1-30—M. & T.—250 Bks.

E 61617

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61617

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Fulton ST. 12-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Cooper

(a) RESIDENCE NO. 717 Fulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Annie Cooper

6 DATE OF BIRTH (month, day, and year) March 1, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipwright

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Boss

(c) Name of employer Toyer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wesley Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt md

12 MAIDEN NAME OF MOTHER Eleanor Archer

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balt md

14 Informant Geo. Cooper

(Address) 717 Fulton St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-30

17 I HEREBY CERTIFY, That I attended deceased from 9-21-30 to 10-22-1930, that I last saw h alive on 10-19-30, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Embolism of the Coronary artery

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. Lee Elvis, M. D.

19 (Address) 924 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-26-1930

20 UNDERTAKER Chas G. Cooper

ADDRESS 514 21 Calhoun St

4 1930

Spec—12-23-21—E.P.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 61618

CERTIFICATE OF DEATH.

179 V

L 61618

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 520 N. Pearl St. 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Matassa

(a) Residence No. 520 N. Pearl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): ✓

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M.

6-DATE OF BIRTH (month, day and year): May 24, 1874

7-AGE: 46 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Lunch room Prop.

(b) General nature of industry, business, or establishment in which employed (or employer): O.H.

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Italy

PARENTS

10-NAME OF FATHER: Michael A.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14- (Informant) Mary Matassa

(Address) 520 N. Pearl St.

15- 192 C. HAMPSON JONES, M. D. Registrar.

OCT 24 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 10-22-30

17- I HEREBY CERTIFY, That I attended deceased from January 1927 to 10-22 1930

that I last saw him alive on 10-22 1930

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Valvular leakage of heart

Chronic nephritis

(Duration) 3 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. 2 mos. 20 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. A. Levin M. D.

10-23 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL. 10-25-1930

20-UNDERTAKER: Fred A. Wagner

ADDRESS 713 Hamm

Spec.—1-30—M. & T.—250 Bks

E 61619 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61619

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Whittier Ave. ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Friedman

(a) RESIDENCE NO. 2211 Whittier Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Pearl Friedman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	11 LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Moses Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hannah-

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Laura E. Katz

(Address) 1439 E. Fayette St.

15 Filed ..... 19 ..... Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929, to Oct 24, 1930, that I last saw him alive on Oct 24, 1930, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. myocarditis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Expiring, M. D.

10/24, 1930 (Address) 2320 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 10-27-1930

20 UNDERTAKER Jack Levine

ADDRESS 1439 E Baltimore St

C. HAMPSON JONES, M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61620 — 38 E 61620

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1431 W. Franklin ST. 14-21 WARD)

2—FULL NAME Beatrice Epps

(a) RESIDENCE NO. 1431 W. Franklin ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Epps

6 DATE OF BIRTH (month, day, and year) Jan 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic,

(b) General nature of industry, business, or establishment in which employed (or employer) at Home. 0.37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Alexander Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant William Epps

(Address) 1431 W Franklin St

FILED 2 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22/30

17 I HEREBY CERTIFY, That I attended deceased from 10/1/30 19 to 10-22- 1930.

that I last saw h[illegible] alive on 10-21- 1930

and that death occurred, on the date stated above, at 12 40 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) C. K. Bolton, M. D.

, 19 (Address) 1512 Belmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 26 1930
20 UNDERTAKER Thomas E Kelson	ADDRESS 1303 Presstman St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61621 E 61621

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 570 W. Mulberry St. 17-25 (WARD)

2-FULL NAME Charles Herbert Randels

(a) RESIDENCE NO. 570 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva Randels

6 DATE OF BIRTH (month, day, and year): Jan 24-1881

7 AGE: Years 49 Months 10 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Windsor, Canada

PARENTS

10 NAME OF FATHER: Joseph Randels

11 BIRTHPLACE OF FATHER (city or town) (State or country): Canada.

12 MAIDEN NAME OF MOTHER: Hannah Hagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant (Address): Eva Randels 570 W. Mulberry St

15 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 23 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to Oct 23, 1930, that I last saw him alive on Oct 23, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Syphilis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual Tests

(Signed) H. Holt Keech M. D.

Oct 24, 1930 (Address) 2502 Calvert Hgts Ln

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Myersville Md. DATE OF BURIAL: Oct 27 1930

20 UNDERTAKER: Bittle Bros. Myersville Md. ADDRESS

FRONT IS very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61622

REGISTERED NO. 168

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1204 Cooksie St. St. 24-35 Ward)

2-FULL NAME Mateus Zuza.

(a) RESIDENCE NO. 1204 Cooksie St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower.

5a If ~~married~~ widowed, or ~~divorced~~
HUSBAND of ~~XXXXXX~~
~~XXXXXXXX~~ Wife of Mary Zuza.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General naturs of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Frances Majewski.
(Address) 1204 Cooksi St.

15 Filed ---- 19-- C. HARRISON JONES, Registrar
24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 22, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide by strangulation.
Strap tied around his neck to foot of bed.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.

10/28/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Oct. 24 1930
20 UNDERTAKER	ADDRESS
John M Weber	401 E. Chester

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61623 188-103 E 61623

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 61623

1-PLACE OF DEATH

City of Baltimore: (No.) University Hospital St., 22 Ward 11

2-FULL NAME William Cuns

(a) RESIDENCE NO. 1904 Mc Culloh St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. _____ mos. _____ ds. How long in U. S., If of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Mary Cuns

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE — Years: 50 — Months: _____ — Days: _____ — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer: _____

9 BIRTHPLACE (city or town) (State or country): Fairforg Co. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mary Cuns 1904 Mc Culloh St.

15 Filed _____ 19 _____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fell from truck upon which he was riding when it collided with another

(duration) 1 yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary): Fract Skull

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? Provident no Warren Ave

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. Brown, M. D.

12/24/1930 (Address) 2939 W. Eldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: 12/24/1930

20 UNDERTAKER: Samuel Hemsley — ADDRESS: Pulaski

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61624 ✓ E 61624

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3084 Preston ST. 11-24 WARD)

2-FULL NAME Margaret Dawson

(a) RESIDENCE NO. 308 W. Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Divorced

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 6

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bessie Moore
(Address) 138 Wing St.

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22/30

17 I HEREBY CERTIFY, That I attended deceased from 10/22 20. to 10/22 20.
that I last saw h alive on 10/21 19 30, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

Signed H. Lee Chi, M. D.
(Address) 524 Orchard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Oct 24 30

ADDRESS —

20 UNDERTAKER Samuel Hawley

ADDRESS Pratt & Bridle

Spec.—1-30—M. & T.—250 Bks.

E 61625

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61625

CERTIFICATE OF DEATH.

REGISTERED NO. 46

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST., 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Fields.

(a) RESIDENCE NO. 1702 Hartman Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Benj. Fields

6 DATE OF BIRTH (month, day, and year) July 5, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 027

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Dunham

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Charlotty Caldwell

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md

14 Informant Friends (Address) Baltimore City or state

15 Filed Oct 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-30

17 I HEREBY CERTIFY, That I attended deceased from 10-20-, 1930, to 10-22-, 1930, that I last saw her alive on 10-22-, 1930, and that death occurred, on the date stated above, at 12 25 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus with local metastases

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Fred W. Ducknall, M. D.

19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Oct 25 30

20 UNDERTAKER Samuel Hawley

ADDRESS 578 Biddle

Spec.—1-30—M. & T.—250 Bks

E 61626 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61626

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: No. 590 St Mary's ST. 17-24 (WARD)

2-FULL NAME Lena Bundy

(a) RESIDENCE No. 590 St. Mary's ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	23	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS
10 NAME OF FATHER: Chas. Bundy
11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]
12 MAIDEN NAME OF MOTHER: Lena Tibbs
13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Carter Richardson (Address) 905 Druid Hill Ave

15 Filed OCT 24 1930 C. HANSON JONES, M. D. Registrar
by .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1930, to Oct 21, 1930,
that I last saw h[illegible] alive on Oct 21, 1930,
and that death occurred, on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) H. Chase Kelly, M. D.
Oct 24, 1930 (Address) 1709 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem | DATE OF BURIAL: Oct 27 1930

20 UNDERTAKER: Arnold Brumley | ADDRESS: 1278 Riddle

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-102E 61627

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Frankford Ave & Ogsan Ave St., Ward) 18 W

2-FULL NAME Eliz Foote

(a) RESIDENCE NO. 1028 Vine St (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Foote

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER A. M. Johnson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Jno Foote
(Address) 1028 Vine St

15 Filed 10-24 1930 HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Struck & knocked down by moving Truck

(b) (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Forsyth & Schroeder

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D Braun M. D.

10 24 1930 (Address) 2939 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 10-24 1930

20 UNDERTAKER Brand Euston

ADDRESS Balto

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61628

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ E 61628

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 16-22 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Bessie Coleman

(a) RESIDENCE NO. 1128 N. Gilmor st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Addie Jett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) C. HUNSON JONES, M. D.

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 19 29, to Oct. 22, 19 30,

that I last saw her alive on Oct. 22, 19 30,

and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral stenosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Lesser, M. D.

10-23 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 10-24 1930

ADDRESS 916 Pa ave

20 UNDERTAKER Leland Carter

10 24 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61629

CERTIFICATE OF DEATH

3 1 ✓ E 61639

REGISTERED NO.

1—PLACE OF DEATH 1420 Gilmor

CITY OF BALTIMORE: (No. 1420 Gilmor ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillie Wilson

(a) RESIDENCE NO. 1420 Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt Mayo Co Md

PARENTS

10 NAME OF FATHER Leo Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Mary Hill

(Address) 1620 Linden Ave

15 Filed ..... 19 ..... C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-30

17 I HEREBY CERTIFY, That I attended deceased from 6-10-30 19 30, to 10-22- 19 30, that I last saw h e alive on 10-20- 19 30, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1420 Gilmor

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W R Boyle, M. D.

, 19 (Address) 1512 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cobb's Wharf MD DATE OF BURIAL 10-24 1930

20 UNDERTAKER Dent Taylor ADDRESS 926

Cor.—10-10-29—A Co.—100 Bks.

E 61630

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61630

CERTIFICATE OF DEATH

183

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St., 17-51 Ward)

2-FULL NAME Robert Owens.

(a) RESIDENCE NO. 113 W-23rd St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ------ mos. ------ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	27	------	------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Richmond Va.
(State or country)

PARENTS

10 NAME OF FATHER: Robert Owens.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Carrie Jefferson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Virginia.

14 Informant: Warner B. Lewis.(C)
(Address): 1525 Winchester St.

15 Filed ..... 19.... THOMPSON JOHNSON, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): October 19, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Internal Hemorrhage due to a self-inflicted pistol shot wound of the abdomen while in a scuffle with Corrinna Davis.(C)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 118 W. 23rd. st. Oct. 18, 1930

Did an operation precede death? No. Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquest.

(Signed) Otto M. Reinhardt, M. D.

(C) 10/28/30 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-24 1930
20 UNDERTAKER: David Carlson	ADDRESS 716 Park

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E61631 ✓ E61631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Iris Eva Bryan

(a) RESIDENCE NO. 2533 Robb St, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): married

5a If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of or) WIFE of Charles J Bryan.

6 DATE OF BIRTH (month, day, and year) ~~May~~ 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Isac Borman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Clara Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Charles J Bryan (Address) 2533 Robb St

15 Filed OCT 24 1930 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23-1930

17 I HEREBY CERTIFY, That I attended deceased from 10-22, 1930, to 10-23, 1930, that I last saw her alive on 10-23, 1930, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Lawrence Lena. M. D.

19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old Town Cemetery — DATE OF BURIAL: Oct 27 1930

20 UNDERTAKER: Robt J. Turner — ADDRESS: 1443 N. Broadway

Spec.—1-30—M. & T.—250 Bks

E 61632 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61632

CERTIFICATE OF DEATH. X 101-001

1-PLACE OF DEATH University Hospital ST. 4-30 WARD)

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD .....

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Jones

(a) RESIDENCE NO. Ellicott city md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND ~~of / or Wife of~~ Hilda Hathaway

6 DATE OF BIRTH (month, day, and year) Sept 8, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry C. Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Georgia Grand.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant James F. Jones
(Address) 1016 Linwood Ave

15 Filed ..... 19 ..... Registrar

FRANCIS JONES M.

241930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Oct 24, 1930, that I last saw him alive on Oct 24th, 1930, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (right)

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) S. Lynn Jr. M. D.

Oct 24, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Louis Cem

DATE OF BURIAL Oct 26 19 30

20 UNDERTAKER E. Easton & Sons

ADDRESS Ellicott City

Spec.—1-30—M. & T.—250 Bks.

24 609
E 61633

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61633

CERTIFICATE OF DEATH.

X 113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Warburton

(a) RESIDENCE No. R F D #10, Sparrows Point ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

If married, widowed, or divorced
HUSBAND) of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27-1930

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Leonard Warburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Dora Keelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1930, to Oct-24, 1930, that I last saw h[illegible] alive on Oct-24, 1930, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Diarrhoea + Entero-colitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Mary adams, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL October 25 30

ADDRESS

UNDERTAKER John O Mitchell + Son

ADDRESS 19 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 61634

E 61634

CERTIFICATE OF DEATH

Curtis Bay 100-001

REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No.) 6311 Marley Neck Rd ST. 75-17 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Todd

(a) RESIDENCE NO. 6311 Marley Neck Rd ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie M Todd

6 DATE OF BIRTH (month, day, and year) Sept 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George C Todd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Hattie H. Stubbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Edgar H Todd
(Address) 2729 Jerome Ave Balto

15 DATE RECEIVED 24 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24/1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1930, to Oct. 24, 1930 that I last saw him alive on Oct. 23, 1930 and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Primary)
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? —

(Signed) Wm. H. Foth M. D.
Oct 24, 1930 (Address) 481 N Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington, North Carolina

DATE OF BURIAL Oct 25 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—1-30—M. & T.—250 Bks

E 61635 E 61635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 X

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 1-76 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Brockington

(a) RESIDENCE NO. 657 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	-	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mess boy

(b) General nature of industry, business, or establishment in which employed (or employer) On Ship

(c) Name of employer

9 BIRTHPLACE (city or town) Saltis
(State or country) S.C.

PARENTS

10 NAME OF FATHER Jerry

11 BIRTHPLACE OF FATHER (city or town) S.C.
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S.C.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed OCT 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19-30

17 I HEREBY CERTIFY, That I attended deceased from 10-10-30, 19..., to 10-19-30, 19...,

that I last saw him alive on 10-19-30, 19...,

and that death occurred, on the date stated above, at 4:05 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs, acute Miliary

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam; lab.

(Signed) Paul Padget, M. D.

10-22 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL OCT 24 1930 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

C. Hampson Jones, M. D. Commissioner Health.

Spec.—1-30—M. & T.—250 Blks

E 61636

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61636

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME George Coleman ? Ridgely

(a) RESIDENCE NO. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 17, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Alfred

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Kitty ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 10-24 1930 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19-30

17 I HEREBY CERTIFY, That I attended deceased from 10-8-30, 19..., to 10-19-30, 19...,

that I last saw h. in alive on 10-19-30, 19...,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) UNKNOWN. yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? In Home & Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Probst. M. D.

Oct 20 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAN

DATE OF BURIAL OCT 24 1930

20 UNDERTAKER

ADDRESS

Commissioner Health

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61637 ✓ E 61637

CERTIFICATE OF DEATH

90

REGISTERED NO. 17-30

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 Lorraine Ave ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret V. Sheeley

(a) RESIDENCE NO. 426 Lorraine ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced: BUSBAND of (or) WIFE of Michael F. Sheeley

6 DATE OF BIRTH (month, day, and year) 10/19/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Patrick Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Whalen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Margaret V. Sheeley

(Address) 426 Lorraine Ave

15 Filed ... 19 ... Registrar

C. HAMPSON JONES M. D.

2 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 19th, 1930, to Oct 23rd, 1930,

that I last saw her alive on Oct 22nd, 1930

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gangrenous Cholecystitis (duration) yrs 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical Evidence

(Signed) Thos Hampson Jones M. D.

1930 (Address) 401 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary Cemetery Govans

DATE OF BURIAL: Oct 25 1930

20 UNDERTAKER: Mary M Redfield

ADDRESS 20 E 22 St

8pec.—1-30—M. & T.—250 Blks

E 61638 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61638

CERTIFICATE OF DEATH. 117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 Rochester Place ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Bohaska.

(a) RESIDENCE NO. 123 Rochester Place ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna V. Bohaska

6 DATE OF BIRTH (month, day, and year) June 20th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Bohaska.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Antonia Stemberk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Anna V. Bohaska (wife) 123 Rochester Place

15 Oct 24 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 nd/30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21 1930, to Oct. 21 1930, that I last saw h[illegible] alive on Oct. 21 1930, and that death occurred, on the date stated above, at 10 50/P. m.

The CAUSE OF DEATH* was as follows: Ruptured appendix with general peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Myocardial Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Paul J. Feng Co M. D.

Oct 23 1930 (Address) 1001 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Oct. 26 1930

20 UNDERTAKER Tilley & Zeiler Inc

ADDRESS 4032 Wolfe St

Spec.—1-30—M. & T.—250 Blks.

E 61639

2/11/29

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61639

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 23-32 WARD)

2-FULL NAME Albert Abbey (Abey)

(a) RESIDENCE NO. 1525 St. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary E. Abey

6 DATE OF BIRTH (month, day, and year) April 13 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 1 day

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Continental Roofing

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Albert Abey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Friends

(Address) Johns Hopkins Hospital

Filed 2 4 1930, 19 C. HAMPSON JONES, M. D. Registrar

By ———

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23-30

17 I HEREBY CERTIFY, That I attended deceased from 10-22-, 19 30, to 10-23, 19 30, that I last saw h.. alive on 10-23-, 19 30, and that death occurred, on the date stated above, at 1525 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia: ? Pneumococcus.

Meningitis: ? Pneumococcus.

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No. Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) C. C. Bidell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL 10.27. 1930

20 UNDERTAKER H. Howard Evans ADDRESS 3[illegible] Eutaw

Spec.—2-29-28—L. F. S.—500 Bks. Adolph A. Liedtke

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61640 E 61640

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Patapsco ST. 24-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adolph A. Liedtke.

(a) RESIDENCE NO. 1435 Patapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 22, 1877.

7 AGE: Years 53. Months 1. Days 23. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist. 031

(b) General nature of industry, business, or establishment in which employed (or employer): U. S. Industrial

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Frederick Liedtke.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Elizabeth Troschwark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Anna Liedke.

(Address): 1435 Patapsco St.

15 Filed 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23 7.45a.m.

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930, to Oct 23, 1930, that I last saw h[e] alive on October 23, 1930, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis & Cystoscopy

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John A. Ehrenfest, M. D.

19 (Address) 1337 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Oct 25 1930

20 UNDERTAKER: E. Howard Evans

ADDRESS: 1 E. Madison

Spec.—1-30—M. & T.—250 Bks

E 61641

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61641

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 S. Lakewood Ave WARD) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Watts

(a) RESIDENCE NO. 1100 S. Lakewood Ave WARD 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of George T. Watts

6 DATE OF BIRTH (month, day, and year) May 22nd 1894

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Jelenowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant George T. Watts (Husband)

(Address) 1100 S. Lakewood Ave

15 10-24-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Oct. 24, 1930, that I last saw her alive on Oct. 24, 1930, and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs of deat

(Signed) J. B. Bronushas, M. D.

10-24-1930 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Oct 27 1930

20 UNDERTAKER Lilly & Guider Inc

ADDRESS 403 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 Bks.

E 61642

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 61642

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 E. Lafayette ST., 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha L. Donoline

(a) RESIDENCE NO. 1738 E. Lafayette Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
WIFE of (or) HUSBAND of Samuel Donoline

6 DATE OF BIRTH (month, day, and year) Sept 16-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D C
(State or country)

PARENTS

10 NAME OF FATHER Otto Frayck

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sam'l Donoline
(Address) 1738 E. Lafayette

15 Filed OCT 24 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Oct 23, 1930, that I last saw h[illegible] alive on Oct 23, 1930 and that death occurred, on the date stated above, at 2.55 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 1929

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Conner L. Read, M. D.

10/24, 1930 (Address) 735 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 25 1930

20 UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61643

CERTIFICATE OF DEATH

188-203 ✓ E 61643

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Lund Hosp St. 4-30 Ward)

2-FULL NAME Kenneth Johnson

(a) RESIDENCE NO. Dorsey Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28 23

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	7	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Dorsey Md
(State or country)

PARENTS

10 NAME OF FATHER Henry W Johnson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Bertha V Wright

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Records
(Address)

15 Filed 11-4 1930 By G. HAMPSON JONES, JR. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run into park by Moving auto

a .....

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dorsey

Did an operation precede death? No Date of 10 23 30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surg

(Signed) L. Frame M. D.

10 24 1930 (Address) 2934 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Cemetery, Dorsey Md — DATE OF BURIAL Oct 26 30

20 UNDERTAKER Mary L. Starr — ADDRESS Ellicott City Md

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61644 E 61644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 20-28 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Lantz

(a) RESIDENCE NO. 120 S. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of George Lantz

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie E. Yeager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records of Balto. City Hospitals

Filed 24 1930 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23-30

17 I HEREBY CERTIFY, That I attended deceased from 10-9-30, 19..., to 10-23-30, 19..., that I last saw her alive on 10-23-30, 19..., and that death occurred, on the date stated above, at 3:00 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic with auricular fibrillation

(duration) more than 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis, pulmonary artery (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Paul Padget, M. D.

10/24/1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Augustines Cemetery

DATE OF BURIAL Oct 27 30

20 UNDERTAKER Harry H. Witzke

ADDRESS 4101 Edmondson

Spec.—2-29-28—L. F. S.—500 Bks.

E 61645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 61645

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 Franklintown Rd. ST., 70-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Hawkins

(a) RESIDENCE NO. 17 Franklintown Rd. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. (nee Richter)

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) Boston,

(State or country) Mass.

PARENTS

10 NAME OF FATHER John Hawkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Mass.

12 MAIDEN NAME OF MOTHER Anna Slattery

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mass.

14 Informant Mrs. Anna E. Hawkins

(Address) 17 Franklintown Rd.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

2 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23rd-30

17 I HEREBY CERTIFY, That I attended deceased from

Aug 6th, 1930, to Oct 23rd, 1930,

that I last saw h[illegible] alive on Oct 23rd, 1930

and that death occurred, on the date stated above, at 540P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Heart

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. F. Janke M. D.

, 19 (Address) 1149 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Oct 27 30

20 UNDERTAKER Harry H. Witzke

ADDRESS Woodbourne

Spec.—1-30—M. & T.—250 Bks.

E 61646 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61646

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Francis Convent ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Ursula Wallace

(a) RESIDENCE No. Chase & Bentalou St. WARD

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ollate Sister

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisiana

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ollate Sister Providence (Address) Chase & Bentalou st.

15 Filed OCT 25 1930 C. HUBERT JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-25-30

17 I HEREBY CERTIFY, That I attended deceased from July, 1930, to Oct. 25. 1930, that I last saw her alive on Oct. 23. 1930, and that death occurred, on the date stated above, at 4:50 p. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual symptoms

(Signed) Mary F. Vaeglein M. D.

10-24, 1930 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Oct. 25, 1930

20 UNDERTAKER Mrs. W. G. Elliott — ADDRESS 17 E. Ashland Ave

Spec.—1-30—M. & T.—250 Bks

61647

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 61647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 8-12

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carter Smith

(a) RESIDENCE NO. 1111 N. Port st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Fredericksburg Virginia

PARENTS

10 NAME OF FATHER Nelson Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Good

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

15 10 25 1930 17 C. HANSON JONES, M.D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1930, to Oct. 22, 1930, that I last saw him alive on Oct. 22, 1930, and that death occurred, on the date stated above, at 12.10 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Hanes Jones, M. D.

10-23, 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Oct. 25 1930

20 UNDERTAKER Mrs. Rilla Elliott

ADDRESS 1725 E. Baltimore

67 129

Spec.—1-30—M. & T.—250 Bks.

E 61648

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61648

111-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Provident Hosp ST., 16-23 WARD)

2-FULL NAME Garrison Thomas Garrison

(a) RESIDENCE No. 1306 W. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced
HUSBAND of or) WIFE of Emmaline Garrison

6 DATE OF BIRTH (month, day, and year) March 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Leah Floyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Garrison
(Address) 1306 W. Lanvale St

15 Filed OCT 25 1930 C. HAMPSON JONES, M. D. Registrar By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23-1930

17 I HEREBY CERTIFY, That I attended deceased from 10-21, 19 30, to 10-23, 19 30, that I last saw h.. alive on 10-23, 19 30, and that death occurred, on the date stated above, at 5:05 a m.

The CAUSE OF DEATH* was as follows:
Ruptured Gastric Ulcer

(duration) ..... yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Peritonitis - Diffuse Obstruction

(duration) ..... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? Yes Date of 10/21/30
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Bernard Harper M. D.
10/23, 19 30 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Oct 26 1930

20 UNDERTAKER John H Bradburn

ADDRESS 1027 Druid Hill

Spec—12-23-21—E.B.R.S.—400 Bks.

E 61649

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61649

74-001

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 204 W. Hamburg St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary E. Dorsey

(a) Residence No.. 204 W. Hamburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced: (Write the word) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1861

7-AGE: 69 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Stephen Boston

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant) Edward Dorsey

(Address) 204 W. Hamburg St.

T 25 1930

H. HAMPSON JONES, M. D. Registrar.

By ....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 26 1930

17- I HEREBY CERTIFY, That I attended deceased from Oct 18, 1930, to Oct 23, 1930, that I last saw h[illegible] alive on Oct 23, 1930, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(Duration) 1 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —?

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) C. H. Flowers M. D.

Oct 23 1930 (Address) 712 S. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL, Oct 26 1930

20-UNDERTAKER: John H. Toadvine — ADDRESS 1027 Druid Hill

Spec.—8-16-29—L. F. S.—100 Bks.

E 61650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 61650

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2221 St. Paul St. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriet Taft Holden

(a) RESIDENCE NO. 2221 St. Paul St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Floyd T. Holden

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Nathan H. Taft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Mary E. Jarvis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Floyd T. Holden

(Address) 2221 St. Paul St.

Filed OCT 25 1930, 19.. C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23-1930

17 I HEREBY CERTIFY, That I attended deceased from October 4, 1930, to October 23, 1930, that I last saw h[illegible] alive on October 23, 1930 and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris -

Arterio-Sclerosis - (duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) (duration) 10 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Besides Symptoms.

(Signed) R. F. Robinson, M. D.

10/24, 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fraternity Cem. Philippi W. Va.

DATE OF BURIAL 10/25/1930

20 UNDERTAKER Henry W. Beades & Son

ADDRESS 220 N. Calvert

B. & O. R. R. Escort Mr. Floyd T. Holden

Cor.—10-10-29—A Co.—100 Bks.

61651

HEALTH DEPARTMENT—CITY OF BALTIMORE

61651

CERTIFICATE OF DEATH

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital 18-26 Ward)

2-FULL NAME Barbara Young

(a) RESIDENCE NO. 1058 W. Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Isaac H. Young.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or ... min.
	59	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H.W. 037
(b) General natore of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indianna
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Indianna

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Isaac H Young
(Address) 1058 W Balto St

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

OCT 25 1930 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident. Fell down steps at 1215 Hollins St. Fracture Skull - Cerebral Hemorage
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. W. Brooks, M. D.

Oct 16 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loundon Parkem	Oct 25 1930
20 UNDERTAKER Robert Brooks Son	ADDRESS Hollins

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 61652

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61652

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore General Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. 27-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Joseph Kelly

(a) RESIDENCE NO. Pimlico Race Track WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8, 1873

7 AGE	Years	Months	Days	If LESS than 1 day.... hrs. or .... min.
	57	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseman

(b) General nature of industry, business, or establishment in which employed (or employer) Race Track

(c) Name of employer Mr. J. P. McGovern

9 BIRTHPLACE (city or town) (State or country) N. Y. U. S.

PARENTS

10 NAME OF FATHER Edward Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records

(Address)

OCT 25 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-30

17 I HEREBY CERTIFY, That I attended deceased from October 20, 1930 to October 22, 1930, that I last saw him alive on October 22, 1930, and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia (duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) acute passive congestion (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at Pimlico Race Track

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & clinical records

(Signed) Joseph J. Laukaitis M. D.

(Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 10-25-30

ADDRESS 1932 Light St

20 UNDERTAKER Margaret G. Flynn

Spec.—1-30—M. & T.—250 Bks.

E 61653

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61653

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 8-17 WARD)

2-FULL NAME Marie Francis Mullen

(a) RESIDENCE NO. 1727 Terrel Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 6 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edgar F. Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lulu Stump

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Edgar F Mullen (Address) 1727 Terrell Place

15 Filed 25 1930 C. HAMPSON JONES, M. D. Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1930, to Oct. 24, 1930, that I last saw her alive on Oct. 24, 1930, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Type undetermined.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Obs.

(Signed) Metas B Cook M. D.

, 19 (Address) 2 Mon Hoop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL OCT 27 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—1-30—M. & T.—250 Bks.

E 61654 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61654

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 Harford Ave. ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M. arcus

(a) RESIDENCE NO. 837 Harford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-18-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	5 6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Marcus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Columbia S. C.

12 MAIDEN NAME OF MOTHER Gertrude Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Trapty Md.

14 Informant Henry Marcus (Address) 837 Harford Ave.

15 Filed 10-25 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 24, 1930, that I last saw h alive on Oct 23, 1930, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mo 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

(Address) 837 Harford Ave. 19 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Osborn Crem

DATE OF BURIAL 10-25 1930

20 UNDERTAKER Byron Wright 1218 McElderry St

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 61655

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 E 61655

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1130 N Gilmor ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Robert Leonard

(a) RESIDENCE NO. 1130 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word):

a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 11-1930

7 AGE: Years | Months: 5 | Days: 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Augustus Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mabel Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Mabel Leonard

(Address) 1130 N Gilmor St

15 [illegible] 19

C. HAMILTON JONES, Registrar

OCT 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 16 1930 to Oct 24 1930

that I last saw him alive on Oct 24 1930

and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Bell, M. D.

10-27 1930 (Address) 713 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 10/25 1930

20 UNDERTAKER: [illegible]

ADDRESS: 17 W Saratoga

Spec.—1-30—M. & T.—250 Bks.

E 61656

E 61656 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61656

CERTIFICATE OF DEATH.

REGISTERED NO. 28-63 129

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Mt Hope Retreat ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bell Moore Wash. D. C.

(a) RESIDENCE NO. Providence Hospital ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
About	80	Unknown		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Supt. Nurses do
(b) General nature of industry, business, or establishment in which employed (or employer) Hospital
(c) Name of employer Providence Hospital

9 BIRTHPLACE (city or town) Unknown
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mt Hope Retreat
(Address) Mt Hope Retreat

Filed OCT 25 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to October 24, 1930, that I last saw her alive on October 24, 1930, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
Arterio - Sclerosis

Unknown (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Senile Dementia (duration) 1 yrs. 0 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) Milton P. Bell, M. D.
, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL S S Peter & Paul Wash. D.C. DATE OF BURIAL 10/29 1930

20 UNDERTAKER E. T. Hartt ADDRESS Washington D.C.

1-30—M. & T.—100 B—50L

E 61657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61657

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1511 Mc Culloh ST. 14-30 WARD

2-FULL NAME Andrew A. Rodgers Jr

(a) RESIDENCE NO 1511 McCulloh ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 9 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew A Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Roberta Black Va

14 Informant Andrew Rodgers

(Address) 1511 McCulloh

Filed T 25 1930 C. HAMILTON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tumor of Brain

(duration) yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary) Paralysis (duration) yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W. H. Holland, M. D. Coroner

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star

DATE OF BURIAL Oct 25/30

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill

Cor.—10-10-29—A Co.—100 Bks.

E 61658

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-006

E 61658

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Union Memorial Hospital St. (Ward) 34

2-FULL NAME Jeremiah Foster

(a) RESIDENCE NO. 1006 Homer St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) "

Informant .....
Address .....

OCT 28 1930

C. HAMPSON JONES, Registrar.

Undertaker .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture Base of Skull.
Contributed to by Injuries
Received by Accidental
Drowning

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

10/24, 1930 (Address) 6732 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn St

DATE OF BURIAL Oct 25 1930

20 UNDERTAKER H. L. Brown & Son

ADDRESS 1014 W. Monty

Spec.—1-30—M. & T.—250 Bks.

E 61659 E 61659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 332 Stimson ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R. Hall

(a) RESIDENCE NO. 332 Stimson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Annie M. Hall

6 DATE OF BIRTH (month, day, and year) Oct 27 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ....min.
	82	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe factory

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 15 yrs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va

PARENTS

10 NAME OF FATHER James B Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ellen Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James B. Hall

(Address) 7210 Harford Rd.

15 Filed Oct 25 1930, 19

C. HAMPSON JONES, M.D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1930, to Oct 27, 1930, that I last saw him alive on October 27, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Finch M. D.

Oct 27, 1930 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Oct 27, 1930

UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

Spec.—1-30—M. & T.—250 Bks.

E 61660 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61660

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 N. Monroe St. 16-23 WARD)

2-FULL NAME Mrs Sarah Swader -

(a) RESIDENCE No. 814 N Monroe St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry M Swader

6 DATE OF BIRTH (month, day, and year) Nov 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Work.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER David Zepp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Fer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Henry M Swader
(Address) 814 N Monroe

15 Filed OCT 25 1930, 19 C. HAMPSON JONES, Registrar.
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-23-30

17 I HEREBY CERTIFY, That I attended deceased from Sept-1, 1930, to Oct-23, 1930, that I last saw her alive on Oct-22-1930, and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach Liver & Intestines -
(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver
(duration) 7 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Maclin M Stroh, M. D.
Oct 23-30 (Address) 8064 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — DATE OF BURIAL Oct 26 1930

20 UNDERTAKER W. M. Coulson — ADDRESS 2235 N Arch

Spec.—1-30—M. & T.—250 Bks

E 61661 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61661

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Fremont & Lem ST. 16-22 WARD)

2-FULL NAME Ada Shores

(a) RESIDENCE NO. 1942 Harlem Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertie Shores

6 DATE OF BIRTH (month, day, and year) Jan 25 94

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James S Benton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucie Messick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bertie Shores
(Address) 1942 Harlem Ave

15 Filed ..... 19... C. HAMPSON JONES, M.D. Registrar

25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1930, to Oct. 23, 1930, that I last saw h[illegible] alive on Oct. 23, 1930, and that death occurred, on the date stated above, at 2:40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebellar Tumor

(duration) ... yrs. 4 mos ... da.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? Yes Date of 10-25-30

Was there an autopsy? No

What test confirmed diagnosis? History, Phys. findings, Operation

(Signed) J. T. Homewood M. D.

10/23, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL Oct 25 1930

20 UNDERTAKER F. J. & W. M. Conlon

ADDRESS 2255 N Mt

Spec.—1-30—M. & T.—250 Bks

E 61662 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61662

CERTIFICATE OF DEATH.

+101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (ST.) 4-7 (WARD)

2-FULL NAME Alberta Warner

(a) RESIDENCE NO. Chestertown, Md (ST.) (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Staines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cora Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records.

(Address)

15 Filed OCT 25 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Oct 24, 1930, that I last saw her alive on Oct 24, 1930, and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Leyho, M. D.

10/25, 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Md

DATE OF BURIAL 10/27 1930

20 UNDERTAKER E. Gordon Farley

ADDRESS 1800 W Fayette

Spec.—1-30—M. & T.—250 Bks.

E 61663

24169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. X49

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lafayette Haines

(a) RESIDENCE NO. Galena Kansas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jennie

6 DATE OF BIRTH (month, day, and year) Feb 21-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer) 25

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10 NAME OF FATHER Stacey Haines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Anna Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Records

(Address) ~~C. HAMPSON JONES, M. D.~~

15 Date received OCT 25 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to Oct 25, 1930, that I last saw h[illegible] alive on Oct 25, 1930, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Bladder Tumor (urinary) Carcinoma

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pyonephritis. Myocarditis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Exam. Cystoscopic Exam

(Signed) Chas G. Jones M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Joplin Mo.

DATE OF BURIAL 10/25 1930

20 UNDERTAKER Hughes & Jones.

ADDRESS 216 Broadway

Spec.—1-30—M. & T.—250 Bks.

E 61664 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61664

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sylcrest Apts. 600 Whitelock St. 13-54 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Kerngood

(a) RESIDENCE NO. Sylcrest Apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Gertrude Kerngood

6 DATE OF BIRTH (month, day, and year) April 16, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER H. Kerngood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Eichenwald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. J. A. Johnson (Address) 800 Chauncey Ave.

15 [illegible] Registrar

OCT 25 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to Oct 24, 1930, that I last saw him alive on Oct 24, 1930, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Subacute Parenchymatous Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Erwin F. Magee M. D.

10/24 1930 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. DATE OF BURIAL: 10/ /1930

20 UNDERTAKER: Harris Sondheimer Son ADDRESS: 1902 Eutaw Place

Spec.—1-30—M. & T.—250 Bks

E 61665 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61665

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 S. Wolfe ST., 2-4 WARD)

2-FULL NAME Annie V. Rettner

(a) RESIDENCE NO. 240 S. Wolfe ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John V. Rettner

6 DATE OF BIRTH (month, day, and year) Dec 17th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William A. O'Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie V. Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. O'Bryan (Niece)

(Address) 240 S. Wolfe St.

15 Filed Oct 26 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1930 to Oct 23, 1930

that I last saw h alive on Oct 22 1930

and that death occurred, on the date stated above, at 2 30/a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. Heller M. D.

10-27, 1930 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Oct. 27 1930

20 UNDERTAKER Lilly & Guilfoile ADDRESS 403 S. Wolfe

L. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks

E 61666

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61666

CERTIFICATE OF DEATH.

REGISTERED NO. 1294

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 132 S. Eaton ST., (or WARD) 26 37

2-FULL NAME Frauke Muller

(a) RESIDENCE NO. 132 S. Eaton ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Margaret Muller

6 DATE OF BIRTH (month, day, and year) June 4th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plater

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Balazius Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant August W. Muller (Son)

(Address) 132 S. Eaton St

15 Filed 26 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1930, to Oct 24, 1930, that I last saw h— alive on Oct 24, 1930, and that death occurred, on the date stated above, at 12 29 p. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Wm. T. Stahmy, M. D.

10/26/30 (Address) 636 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Oct 28th 1930

20 UNDERTAKER Lilly + Zeiler Inc

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks

E 61667

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61667

CERTIFICATE OF DEATH.

REGISTERED NO. 16-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1824 E. Chase ST., 7-13 (WARD)

2-FULL NAME George E Mauler.

(a) RESIDENCE NO. 1824 E Chase ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Oct 23-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Mauler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Struck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Joseph Mauler. Father 1824 E Chase St.

15 Filed OCT 26 1930 C. HAMPSON JONES Registrar

16 Reg. 0665

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-23-30 to 10-24-30 19

that I last saw h[illegible] alive on 10-24-30 19

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Contusions of Forces of Cerebral Hemorrhage 2 da.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Principal Contusions

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? (No) Clinical

What test confirmed diagnosis? J Hillard

(Signed) M. D.

10-24 1930 (Address) 2214 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL Oct 29 1930

20 UNDERTAKER J. Kelly & Sons Inc ADDRESS 403 S. Mosher St

Spec.—1-30—M. & T.—250 Blks

E 61668 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61668

CERTIFICATE OF DEATH. 31

REGISTERED NO. 6537

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6716 Hudson ST., 26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dodd Holman

(a) RESIDENCE NO. 6716 Hudson ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm V. Holman

6 DATE OF BIRTH (month, day, and year) June 16th 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~ Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gratonville Md.

PARENTS

10 NAME OF FATHER George P. Ebersee

11 BIRTHPLACE OF FATHER (city or town) Queenstown (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary J. Dodd

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Wm V. Holman

(Address) 6716 Hudson St.

15 Filed 2 1930 H. HAMPSON JONES, M. D., Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 24th, 1930, to Oct 23rd, 1930; that I last saw her alive on Oct 23rd, 1930, and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4700 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL Oct 27th 1930

20 UNDERTAKER Lilly & Zeiler Fun.

ADDRESS Hard. Ways & Co

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61669 E 61669

CERTIFICATE OF DEATH

129

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2919 Norfolk ave ST. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michel Milliman

(a) RESIDENCE NO. 2919 Norfolk ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Yetta

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER David Milliman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

PARENTS

14 Informant Yetta Milliman

(Address) 2919 Norfolk ave

15 Filed OCT 26 1930 19 HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 21. 1930 to Oct 24th 1930

that I last saw him alive on Oct 24th 1930

and that death occurred, on the date stated above, at 3704 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Rt side)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardio-vascular-renal disease (duration) yrs.? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. V. Hargett M. D.

Oct 25, 1930 (Address) 5208 Liberty Oak Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cemetery

DATE OF BURIAL Oct 26 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 Balto. st

Spec.—2-29-28—L. P. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61670 118-001 E 61670

CERTIFICATE OF DEATH

1—PLACE OF DEATH West Balto. Gen. Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. Raynor ST. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Frances Keller

(a) RESIDENCE NO. 1600 N Stephen ST., WARD

(Usual place of abode) (If non-resident give city or town

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. m

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

6 a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabury P. Keller

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Robert Dudrow

11 BIRTHPLACE OF FATHER (city or town) Frederick? (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Felty

13 BIRTHPLACE OF MOTHER (city or town) Frederick? (State or country) Maryland

14 Informant Mrs. Fannie Keller Daughter

(Address) 160 N Stephen St.

15 Filed 10/26 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23

17 I HEREBY CERTIFY, That I attended dece

Oct. 22, 1930, to Oct 23

that I last saw her alive on Oct. 23

and that death occurred, on the date stated above, at 8

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. mos. 5 hrs ds.

CONTRIBUTORY (Secondary) Mutual Registration - Candidate Member (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct. 23, 1930

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) H Ashman, M. D.

10/23, 1930 (Address) W & B Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Oct. 27 1930

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

3416-40.
61671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61671

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7037 WARD)

2-FULL NAME Amy Fairfield

(a) RESIDENCE NO. 506 Rapella St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Geo Fairfield

6 DATE OF BIRTH (month, day, and year) Mch. 30 - 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of Industry, business, or establishment in which employed (or employer) At home 037

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Wales -

PARENTS

10 NAME OF FATHER Thomas Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Mary Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed [illegible] 19 1930 E. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1930, to Oct. 25, 1930, that I last saw her alive on Oct. 25, 1930, and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Arteriosclerosis

Auricular fibrillation

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Multiple pulmonary emboli

(duration) yrs. mos. 15 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Barney M. Billings Jr. M. D.

Oct 25, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 10 28 1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

No Geo Dr 26ff 2020 N. Chas St
Unit 0565

E 61672

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61672

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3632 Beech Ave ST. 13-52 WARD)

2-FULL NAME Laura V. Smith

(a) RESIDENCE NO. 3632 Beech Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of or) WIFE of Late Wm J. Smith

6 DATE OF BIRTH (month, day, and year) Dec 4th 1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Richard Nace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Caroline Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Carrie Dushay

(Address) Middle River Md

Filed OCT 26 1930, 19 R.H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Oct 24, 1930

that I last saw h.er alive on Oct 24, 1930

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Valv. Heart Dis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Chron. Brights

(duration) 2 yrs. mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) [illegible] M. D.

10/25 1930 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Cemetery

DATE OF BURIAL 10/27/1930

20 UNDERTAKER Wm Cook

ADDRESS 127 St Paul st

Spec.—1-30—M. & T.—250 Bks.

E 61673

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61673

CERTIFICATE OF DEATH.

49

REGISTERED NO. D

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bellona Ave Garrett (STREET OR WARD) Edgewood Sanitorium 14

2-FULL NAME Julia F. Beck

(a) RESIDENCE NO. 1935 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/20/1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 68

(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER G. Herman Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bollman

13 BIRTHPLACE OF MOTHER (city or town) Pittsburg Pa (State or country)

14 Informant C. Ernest Beck

(Address) Ellicott City Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930, to Oct 25, 1930, that I last saw h.. alive on Oct 25, 1930, and that death occurred, on the date stated above, at 4:10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pleural Effusion

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? 1935 Park Ave Aug 1930 by (?) Dr. Wharton

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Physical findings

(Signed) W. W. B. Lewis, M. D.

10/25/1930 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 10/28/1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 St Paul St

2613 HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

(Gavin)

E 61674

E 61674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3rd & Eutaw St. ST. 9-46 WARD)

2-FULL NAME William Gavin Jr

(a) RESIDENCE NO. 702 Reese St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Gavin

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Emma Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Records.

(Address)

Filed 10-26-1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Oct 25, 1930,

that I last saw h. alive on Oct 25, 1930,

and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Dehydration & malnutrition

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 702 Reese St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) R. Pearce M. D.

10/26, 1930 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Homeland

DATE OF BURIAL 10/27 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61675 181-09 ✓ E 61675

REGISTERED NO. 21-31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) South Baltimore General Hospital (Ward)

2-FULL NAME Wilhelmina Formhals.

(a) RESIDENCE NO. 937 Ridgely St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow.

5a If ~~MARRIED, widowed~~ ~~XXXXXXX~~ ~~XXXXXXX~~ (or) WIFE of Jacob Formhals.

6 DATE OF BIRTH (month, day, and year) July 21, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	78	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER John Stoll.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Marie Euler.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant (Address) Charles W. Reinhardt. (son) 815 Scott. St.

15 Filed ... 19 ... Registrar

261939

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 24, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental illuminating gas poisoning.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 937 Ridgely St. Oct. 24, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) ... M. D.

10/25 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL Oct 27 1930

20 UNDERTAKER Mr & Mrs J W Teufel & Son — ADDRESS 801 W Fayette

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 61676

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61676

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Cramer

(a) RESIDENCE NO. 235 S. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lydia Cramer

6 DATE OF BIRTH (month, day, and year) — 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired teacher

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jan Cramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lydia —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Lewis

(Address) 1439 E. Eden St.

15 [illegible] 19 HAMPSON JONES, M. D. Registrar

26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/30

17 I HEREBY CERTIFY, That I attended deceased from 9/27, 1930, to 10/25/, 1930, that I last saw h/ alive on 10/25/, 1930, and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? E. K. G.

(Signed) Emerson B. Cook, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 10-26-1930

20 UNDERTAKER Jack Lewis, 1439 E. Eden St. — ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 61677 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61677

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3220 Piedmont Ave., ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Levin

(a) RESIDENCE NO. 3220 Piedmont Ave. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Israel Levin

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 58; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): I. Levin 1439 E Baltimore St

Filed 10-26-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year): 10-25-30

17 I HEREBY CERTIFY, That I attended deceased from 4/3, 19 30, to 10-24, 19 30, that I last saw h[illegible] alive on 10-24, 19 30, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Apr 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) A. S. Hamilton, M. D.

10/25 19 30 (Address) 733 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Herrmann Wash Road

DATE OF BURIAL: 10-26-1930

ADDRESS

20 UNDERTAKER: Jack Levin, 1439 E Baltimore St

Spec.—1-30—M. & T.—250 Bks.

E 61678 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61678

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 E. 20th St. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Degler

(a) RESIDENCE NO. 420 E. 20th st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Chas J. Degler.

6 DATE OF BIRTH (month, day, and year) Mar. 3

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	7	21	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Kelleher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Not Given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Given.

14 Informant Chas. J. Degler

(Address) 420 E. 20th

Filed 26 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24/30

17 I HEREBY CERTIFY, That I attended deceased from 7/25, 1930, to 10/24, 1930, that I last saw h[illegible] alive on 10/22, 1930, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the breast (R)

(duration) 8 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Metastasis - Lung,

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug/28

Was there an autopsy? No Laboratory

What test confirmed diagnosis?

(Signed) Dr Bernard Wolff M. D.

10/24 1930 (Address) 1216 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Oct 27-30
20 UNDERTAKER Geo M. Emick & Son	ADDRESS 811 N Mt St.

Spec.—1-30—M. & T.—250 Bks

E 61679

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61679

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Brady

(a) RESIDENCE NO. Owings Mills, Md ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
—	3 mos		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work) none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William M. Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Hagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records (Address)

15 FILED 2-6 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/30

17 I HEREBY CERTIFY, That I attended deceased from 10/18/30, 19 ..... to 10/25/30, 19 ....., that I last saw h[illegible] alive on 10/25/30, 19 ....., and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows: Fermentation Disorder

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Oral nutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Leyko, M. D.

10/26 19 30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Family Cemetery

DATE OF BURIAL 10/27 1930

20 UNDERTAKER Frank H. Newell

ADDRESS Pikesville, Md

Spec.—1-30—M. & T.—250 Bks

E 61680

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61680

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2629 Wyeliffe Rd ST. 27-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Gaulin

(a) RESIDENCE NO. 2629 Wyeliffe Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frieda Gaulin

6 DATE OF BIRTH (month, day, and year) Aug. 28/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James A. Gaulin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Mace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Frieda Mattes

(Address) 2612 Creighton Rd.

15 Filed 26 1930 C. HAMPSON JONES, Registrar

By RR FF

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 24/30

17 I HEREBY CERTIFY, That I attended deceased from October 14 1930 to October 24 1930

that I last saw him alive on October 20, 1930

and that death occurred, on the date stated above, at 5:30 a/m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) several years yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis (duration) many years mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B Green M. D.

Oct 25 1930 (Address) 5543 Harford Rd Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL Oct. 27 1930

20 UNDERTAKER Wm. C. Willis & Co

ADDRESS 2334 Jefferson St.

Spec.—1-30—M. & T.—250 Bks.

E 61681 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61681

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. [illegible] ST. [illegible] WARD)

2-FULL NAME Louis Freshi - Fralber

(a) RESIDENCE NO. 821 Eastern ST., [illegible] WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rose Freshi

6 DATE OF BIRTH (month, day, and year) Sept 26 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Freshi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Louis Freshi (Address) [illegible]

15 Registered [illegible] 19 Per [illegible] Registrar

26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/30

17 I HEREBY CERTIFY, That I attended deceased from 9-18-30, 19..., to 10-25-30, 19...,

that I last saw h[illegible] alive on 10-25-30, 19...,

and that death occurred, on the date stated above, at 5 40 a. m.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY, (Secondary) Myocarditis & Cirrhosis (duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 9/26/30

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) [illegible], M. D.

, 19 (Address) Sea Breeze Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Oct 28 1930

20 UNDERTAKER M. F. & E. Duppel Inc — ADDRESS 372 Gunther

Spec.—1-30—M. & T.—250 Bks.

Dr Greenberg Easton Md 132 St

E 61682

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61682

44

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 Tamery ST. 26-37 WARD)

2-FULL NAME Loran L Dowell

(a) RESIDENCE NO. 132 Tamery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of or) ~~WIFE of~~ Pearl E. Dowell

6 DATE OF BIRTH (month, day, and year) 11/3/1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Wright

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Works

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo F. Dowell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mason Graves

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Pearl E. Dowell

(Address) 132 Tamery St

15 Filed 26 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25th 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/25, 19 30, to 10/25, 19 30, that I last saw h[illegible] alive on 10/25, 19 30, and that death occurred, on the date stated above, at 9.15 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Carcinoma

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Municipal Hosp.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Greenberg M.D.

10/26/1930 (Address) 1401 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Solomons Island — DATE OF BURIAL 10/27/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Pratt St

Spec.—1-30—M. & T.—250 Bks.

E 61683

E 61683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143-002

REGISTERED NO.

1-PLACE OF DEATH 22 Druid Hill Ave

CITY OF BALTIMORE: (No. 2 Eutaw St., 1556 WARD) 26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis S. Enson

(a) RESIDENCE NO. 2932 Westwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed,~~ or ~~Divorced,~~ (write the word): Married

5a If married, ~~widowed~~, or divorced HUSBAND of or) WIFE of: J. Sherman Enson

6 DATE OF BIRTH (month, day, and year): January 17 1895

7 AGE: Years 35 Months 9 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Md

PARENTS

10 NAME OF FATHER: James Kelbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ida B Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: J Sherman Enson

(Address): 2932 Westwood Ave

15 Filed: OCT 26 1930 By: C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-25-30

17 I HEREBY CERTIFY, That I attended deceased from 10-24-30, 19..., to 10-25-30, 19...,

that I last saw h alive on 10-25-30, 19...

and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Ruptured right ectopic pregnancy - Hemorrhage

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) for yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/24/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) A M Henderson, M. D.

, 19 (Address) 22 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Md

DATE OF BURIAL: Oct 28 1930

20 UNDERTAKER: Geo W Little

ADDRESS: 2700 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

E 61684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 ✓ E 61684

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) Mercy Hosp St., 1-1 Ward)

2-FULL NAME Hilda Flaherty

(a) RESIDENCE NO. 711 S. Lakewood St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 28 1906

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	24	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work clk
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Dan J. Flaherty

11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country)

12 MAIDEN NAME OF MOTHER Nuda Ekner

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant Dan E. Flaherty
(Address) 711 S. Lakewood Ave

261930 C. HAMPSON JONES, M. D., Registrar
Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows: Thrown out of auto in which she was riding

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Cold'r Madison

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Hamill M. D.

Oct 23 1930 (Address) 2939 Mt Olivet

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL Oct 27 1930

20 UNDERTAKER John A. Moran — ADDRESS 3007 E Balto

important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61685

CERTIFICATE OF DEATH.

167-001

E 61685

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Savas Hariton

(a) RESIDENCE NO. 115 N. Freemont Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Haxo Turkey

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Greece

14 Informant Christos Charolambon

(Address) 156 N. Exeter St.

26 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoned by illuminating gas. Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Eugene Tilbert M. D. (Coroner)

10/27 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial Oct 27 1930

20 UNDERTAKER John M. Weber ADDRESS 401 N. Chester St.

Very important. See instructions on back of certificate.

Spec.—2-29-28—I. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61686 113 ✓ E 61686

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. Linden Ave ST. 1127 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Sauer

(a) RESIDENCE NO. Essex Md ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	S.

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6 Months	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Summerville Md

PARENTS

10 NAME OF FATHER George Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Magdalene Bratz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Parents

(Address) Essex Md.

15 OCT 26 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 21, 1930, to October 25, 1930, that I last saw h[illegible] alive on October 25, 1930 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Colitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert F. Chronister, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Oct. 27 1930

20 UNDERTAKER John G. Connelly

ADDRESS Essex

Spec.—1-30—M. & T.—250 Bks.

E 61687 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61687

CERTIFICATE OF DEATH.

REGISTERED NO. 12-49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Baker Symington

(a) RESIDENCE NO. Rogers Forge, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ ~~or WIFE OF~~ Mr John F Symington

6 DATE OF BIRTH (month, day, and year) Nov. 11 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlottesville, Va

PARENTS

10 NAME OF FATHER Samuel Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Louise McIntire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John F. Symington (Address) Rogers Forge Md

OCT 27 1930

C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept 7th, 1930, to Oct 26th, 1930, that I last saw her alive on Oct 26th, 1930, and that death occurred, on the date stated above, at 4 30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(duration) 3 yrs. (?) mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 10th

Was there an autopsy? No

What test confirmed diagnosis? Operation (Exploratory)

(Signed) Richard France, M. D.

6426 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Darlington Glen Harford Co	Oct 28 1930
UNDERTAKER Henry Jenkins & Son Co	ADDRESS Cathedral Mt Vernon Pl

Spec.—8-16-29—L. F. S.—100 Bks.

E 61688

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61688

CERTIFICATE OF DEATH

REGISTERED NO. 74

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 N. Streeper ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Sedlacek

(a) RESIDENCE NO. 707 N Streeper ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years 66; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Milevsko Bohemia

PARENTS

10 NAME OF FATHER: Anton Sedlacek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Anna Prasek

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Rosa Fuba

(Address) 707 N Streeper St

15 [illegible] 19[illegible]

27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 24, 1930, that I last saw her alive on Oct 24, 1930 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary): Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Ernest M. D.

Oct. 26 1930 (Address) 881 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 27. 1930

20 UNDERTAKER: Frank Bracken — ADDRESS: 1906 Eutaw

Spec.—8-16-29—L. F. S.—100 Bks.

E 61689

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001
101 E 61689

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Park Ave ST., 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah H Janney

(a) RESIDENCE NO. 2001 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 4-1853

7 AGE Years	Months	Days	If LESS than 1 dsy, hrs. or min.
77	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Wash. D.C.

PARENTS

10 NAME OF FATHER Henry Janney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hannah Scofield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant Miss Bertha Janney

(Address) 2001 Park Ave

15 Filed OCT 27 1930 G. HAMPSON JONES, M. Registrar

BY —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25-1930

17 I HEREBY CERTIFY, That I attended deceased from October 24, 1930, to October 25, 1930, that I last saw h[illegible] alive on October 25, 1930 and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Was it inside

What test confirmed diagnosis? Clinical Examinations + Symptoms

(Signed) A. F. Robinson, M. D.

Oct 27, 1930 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friends Cemetery — DATE OF BURIAL Oct 27 1930

20 UNDERTAKER Chas. E. Franck — ADDRESS 801 Madison Ave

Spec.—2-29-28—L. F. S.—500 Bks.

Mrs Margaret R Tucker

E 61690

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61690

105

CERTIFICATE OF DEATH

REGISTERED NO. 28-66

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 837 Brinkwood St. (WARD)

2—FULL NAME Mrs Margret R Tucker

(a) RESIDENCE NO. 837 Brinkwood Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: W. O. Tucker

6 DATE OF BIRTH (month, day, and year): Dec. 14/1856

7 AGE: Years 73; Months 10; Days 14; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: John P Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca Clay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm O. Tucker

(Address) 837 Brinkwood Rd

15 Filed 27 1930 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930 to Oct 26, 1930

that I last saw h alive on Oct 25, 1930

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial asthma (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John N Evans, M. D.

Oct 26 1930 (Address) 612 W 40 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Oct. 28 1930

20 UNDERTAKER: John E. Branch ADDRESS: 802 Madison Ave

Spec.—1-30—M. & T.—250 Bks.

E 61691

E 61691 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 2-A WARD)

2-FULL NAME Theresa Hodnicki

(a) RESIDENCE NO. 723 S. Bethel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ND

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leon Hodnicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Bertha Goldys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Bertha Hodnicki
(Address) 723 Bethel

Filed ..... 19 ..... C. HINSON JONES, M. D.
Registrar

OCT 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26-30

17 I HEREBY CERTIFY, That I attended deceased from 10-22- , 1930, to 10-26 , 1930,
that I last saw h[illegible] alive on 10-26 , 1930,
and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(Type undetermined)
(duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary) Enteritis + Pyelitis + Otitis
media (duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray

(Signed) Milton B Idrus, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Rosary Cem — DATE OF BURIAL Oct 27 1930

20 UNDERTAKER John M Weber 401 E Chester — ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

E 61692

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61692

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Cambridge Apt. St. 12-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Mallory Dufur

(a) Residence No. Cambridge Apt. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Geny Dufur

6-DATE OF BIRTH (month, day and year): Nov 14th 1866

7-AGE: 63 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): New Haven, Conn

PARENTS.

10-NAME OF FATHER: Eliada B. Mallory

11-BIRTHPLACE OF FATHER (city or town) (State or Country): New Haven Conn

12-MAIDEN NAME OF MOTHER: Charlotte Bradley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): New Haven Conn.

14- (Informant) Mrs. William G. Dufur (Husband)

(Address) Cambridge Apts.

15-

C. HAMPSON JONES, M. D. Registrar.

T 27 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 26, 1930

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1930 to Oct 26 1930.

that I last saw her alive on Oct 26 1930.

and that death occurred, on the date stated above, at 3-35 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(Duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. G. Dufur M. D.

, 19 (Address) 522 E Hamilton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: October 29th 1930

20-UNDERTAKER: Stewart & Moore Company

ADDRESS: 108 W North Ave

Spec. 1-30—M. & T.—250 Bks.

E 61693

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61693

CERTIFICATE OF DEATH.

91-502

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Little Sisters of the Poor ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Bochmer

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Bochmer

6 DATE OF BIRTH (month, day, and year) July 3rd 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 80

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Bochmer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Clara Spaunder

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sister of the Poor (Address) Preston & Valley St

15 Filed Oct 29 1930 H. HANSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 26, 1930, that I last saw h. alive on Oct 25, 1930, and that death occurred, on the date stated above, at 3.20 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Bernard Gill M. D.

10/29/30 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Oct 29, 1930

20 UNDERTAKER Chas. W. Dill.

ADDRESS 3109 Fredk Ave

Spec.—1-30—M. & T.—250 Bks

E 61694

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61694

CERTIFICATE OF DEATH.

129

REGISTERED NO. 15-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3808 Ridgewood ST. WARD 5

2-FULL NAME Mary F. Stokris

(a) RESIDENCE NO. 3808 Ridgewood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Stokris

6 DATE OF BIRTH (month, day, and year) June 4 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo W. Waldeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Zapf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Maud Ludwig

(Address) 3808 Ridgewood St

Filed OCT 27 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1930, to Oct 24, 1930,

that I last saw h[illegible] alive on Oct 23, 1930,

and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic Regurgitation

Chronic Nephritis

(duration) yrs. 6 mos 24 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj F. Owens, M. D.

10/25/30 (Address) 4003 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Oct 27/30 19

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Eutaw St

Spec.—1-30—M. & T.—250 Bks.

E 61695 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓179 E 61695

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Memorial Hospital
CITY OF BALTIMORE: (NO. 3 3rd & Calvert ST. 12-19 WARD)

2-FULL NAME Ruth McCauley

(a) RESIDENCE NO. 1813 Guilford ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 6, 1927

7 AGE	3 Years	6 Months	19 Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER James McCauley
11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)
12 MAIDEN NAME OF MOTHER Evelyn Payne
13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Hospital records.
(Address)

15 Filed 27 1930 19 FRANCON-JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25/30

17 I HEREBY CERTIFY, That I attended deceased from October 24 19 30, to October 25 19 30,
that I last saw h.. alive on October 25 19 30,
and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:
Burns 1st & 2nd degrees (Covered by adhesive material)
Accidental Coroner J Thomas O.K.
(duration) 0 yrs. 0 mos ✓ ds.

CONTRIBUTORY
(Secondary) —
(duration) 0 yrs. 0 mos. ✓ ds.

18 Where was disease contracted if not at place of death? 1813 Guilford ave Baltimore
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Laboratory findings
(Signed) R Vance M. D.
10/25/1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn
DATE OF BURIAL Oct 27/30

20 UNDERTAKER Philip Herwig
ADDRESS 2016 Edmondson Ave

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

61696

REGISTERED NO. E 61696

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 629-Llewelyn av (ST.) 8-16 (WARD)

2-FULL NAME Catherine L. Tress.

(a) RESIDENCE NO. 629-Llewelyn av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/19/28

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	2	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Walter J. Tress Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret V. Sloseny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Margaret Tress

(Address) 629 Llewelyn av

71930 Jan 5 1931 H. LAMSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia probably gastro-intestinal

(duration) yrs. mos ds.

Convulsions

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Weems, M. D. Coroner

Oct. 27 19 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dale Cemetery Essex.

DATE OF BURIAL 1/5/31 19 30.

20 UNDERTAKER Guy J. Smith Inc

ADDRESS 1733 Hoppy Av

Spec.—1-12-23—M&T—500 Bks.

E 61697 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61697

CERTIFICATE OF DEATH.

REGISTERED NO. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1043 Sharp ST. 2331 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorethea Jones

(a) RESIDENCE NO. 1043 Sharp ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Student

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Rockhill, S. C.

PARENTS

10 NAME OF FATHER Samuel Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rockhill S. C.

12 MAIDEN NAME OF MOTHER Marie Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rockhill S. C.

14 Informant Samuel Jones (Address) 1043 Sharp St

15 Filed [illegible] C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/1930

17 I HEREBY CERTIFY, That I attended deceased from 10/23/1930, to 10/25/1930, that I last saw h[illegible] alive on 10/25/1930, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Lepto meningitis; Septicemia followed by Cardiac & Respiratory failure.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Otitis media Staphylo coccic (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical & History

(Signed) W. H. Parker M. D.

, 19 (Address) 727 Shard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Oct. 27 1930

20 UNDERTAKER C. R. Brown & Son

ADDRESS 1201 W. Mon[illegible]

1-30—M. & T.—100 B—50L

E 61698

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 ✓

E 61698

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1112 N. Stricker ST. 16-22 (WARD)

2-FULL NAME Catherine Smith

(a) RESIDENCE NO. 1112 N Stricker ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: N S

6 DATE OF BIRTH (month, day, and year): Dec 20 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Ingram

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delta Miss

14 Informant: Mrs. Smith

(Address): 1112 N Stricker

Filed: 2 7 1930, 19 .... THAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) ..... M. D. Coroner

, 19 .... (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Oct 27 1930

20 UNDERTAKER: Clarence Edelmann — ADDRESS: 1001 Fulton Ave

Spec.—1-30—M. & T.—250 Bks

E 61699

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61699

1-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 1-3 WARD)

2-FULL NAME Frank Butler or Bridgers

(a) RESIDENCE NO. 902 S. Belnord Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	19	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mercersburg, Pa.

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna Frisby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Records of
(Address) Balto. City Hosp.

Filed OCT 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24-30

17 I HEREBY CERTIFY, That I attended deceased from 10-17-30, 19..., to 10-24-30, 19...,

that I last saw him alive on 10-24-30, 19...,

and that death occurred, on the date stated above, at 6:25 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) Heart disease. UNKNOWN.

Pneumatic (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cultures & Exam.

(Signed) Paul Podgel. M. D.

10-X, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL 10/27 1930

20 UNDERTAKER Mrs Chas T. Bailey

ADDRESS 1421 Jefferson St

Spec—9-30—A. & Co.—250 Bks

E 61700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 61700

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No 1121 Monroe Circle Eastern Ave WARD)

2. FULL NAME Mary Virginia Jackson

(a) RESIDENCE No. 1121 Monroe Circle Eastern Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Oregon Jackson

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Dora Hagar

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Oregon Jackson
(Address) 1121 Monroe Circle Eastern Ave

15 Filed ..... 19 ..... Registrar

27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930 to Oct 24, 1930

that I last saw her alive on Oct 24, 1930

and that death occurred, on the date stated above, at 2.50 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lee D. Hedrick M. D.

(Address) 4700 Fleming Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship Anna Arundel Co

DATE OF BURIAL Oct 28 1930

20 UNDERTAKER: Chenoweth Son

ADDRESS 3615 Harford

Spec—9-30—A. & Co.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61701 — 131 E 61701

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 3602 Linwood & Bus) (ST.) 15-25 (WARD)

2 FULL NAME Clara M. Jackson

(a) RESIDENCE NO. 3602 Linwood Ave (ST.) (WARD)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Orland Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Clara M. Lindsay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): 3602 Linwood Ave.

15 Filed ... 1930 ... 19 ... Registrar: WILSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 1930 to Oct 25 1930

that I last saw her alive on Oct 25 1930

and that death occurred, on the date stated above, at 3:54 p.m.

The CAUSE OF DEATH* was as follows: Enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Hotka, M. D.

(Address) 4702 Kenwood Ave 1930

*State the Disease Causing Death, or In deaths from Violent Causes State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship Memorial Park — DATE OF BURIAL: Oct 28 1930

20 UNDERTAKER: Chas. W. Low — ADDRESS: 3615 Chestnut Ave.

Spec.—9-30—A. & Co.—250 Bks.

E 61702 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61702

CERTIFICATE OF DEATH.

REGISTERED No. 88

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 W. 37th St. ST. 13-52 WARD)

2. FULL NAME Eugene W. Brooks.

(a) RESIDENCE No. 1007 W. 37th St. ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence E. Brooks.

6 DATE OF BIRTH (month, day, and year) March 5, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rigger.

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Transfer Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jesse E. Brooks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Mc Cauley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Brooks.

(Address) 1007 W. 37th St.

15 27 1930 H. LAMDIN JOHNS, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1930, to Oct. 24, 1930 that I last saw him alive on Oct. 23, 1930 and that death occurred, on the date stated above, at 11.55 A.M.

The CAUSE OF DEATH* was as follows:

Hypocarditis

(duration) yrs. mo 33 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis Emphysema

(duration) yrs. mos. 53 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs + symptoms

(Signed) F. H. Lamdin M. D.

(Address) 403 Fallsway 19

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden — DATE OF BURIAL Oct 27 30

20 UNDERTAKER Chunowith & Son — ADDRESS 325 Chestnut Ave

Cor.—10-10-29—A Co.—100 Bks.

E 61703

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+90 E 61703

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 374 Forrest St. St. 5-8 Ward)

2-FULL NAME Antonette Di'Cecco.

(a) RESIDENCE NO. 374 Forrest St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. — ds. How long in U. S., if of foreign birth? 0 yrs. 4 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, ~~Widowed, or Divorced~~ (or) WIFE of Nicholas Di'Cecco.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	-------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None. 07
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy.
(State or country)

PARENTS

10 NAME OF FATHER Donato Tiracchia

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy.

12 MAIDEN NAME OF MOTHER Carolina.-------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy.

14 Informant Nazareno Saloni. (cousin.
(Address) 374 Forrest St.

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 24, 1930 [92]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hypertrophy and acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & inquiry

(Signed) H. M. Kemtadt, M. D.

10/27 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	10 28 1930
20 UNDERTAKER	ADDRESS
Geo. F. Kuth Inc. 1735	Harford Ave

Important. See instructions on back of certificate.

71930

Spec.—1-30—M. & T.—250 Blks

E 61704

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61704

CERTIFICATE OF DEATH.

REGISTERED NO. 11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4448 Wrenwood Ave. ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Lehnhoff

(a) RESIDENCE NO. 4448 Wrenwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Harry C. Lehnhoff

6 DATE OF BIRTH (month, day, and year) June 29, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

PARENTS

10 NAME OF FATHER James A. Wagross

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Willinghan

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Md.

14 Informant Harry C. Lehnhoff (Address) 4448 Wrenwood Ave.

15 Filed 10/27 1930 19 per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 16th, 1930 to Oct 26th, 1930,

that I last saw her alive on Oct 26th, 1930,

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —?

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Thos. J. Hargrove, Jr. M. D.

10/26/30 (Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Oct. 28 1930

A UNDERTAKER Frederick Lassahn Son

ADDRESS 7401 Belair Rd.

Spec.—1-30—M. & T.—250 Bks

E 61705 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 E 61705

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Gorsuch Ave. ST. 9-46 WARD)

2-FULL NAME Albert Streett

(a) RESIDENCE NO. 1125 Gorsuch Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. Catherine Streett

6 DATE OF BIRTH (month, day, and year) July 12, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Corbin G. Streett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Nancy Streett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co., Md.

14 Informant Mrs. William R. Patton (Address) 1125 Gorsuch Ave.

15 Filed 27 1930 19 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 18, 1930, to October 26, 1930, that I last saw him alive on October 25, 1930, and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) some mos ds.

CONTRIBUTORY (Secondary) Cretal Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Thomas Tuttle, M. D.

10/27/1930 (Address) 2480 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cooptown M. E. Cemetery

DATE OF BURIAL Oct. 28, 1930

20 UNDERTAKER Frederick Lissau and Son

ADDRESS 7401 Belair Rd.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61706

CERTIFICATE OF DEATH

74001

E 61706

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 16-67 Ward)

2-FULL NAME Pinkney S. Gorsuch.

(a) RESIDENCE NO. 2917 Mosher St. St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of ~~WIFE of~~ Clara Gorsuch.

6 DATE OF BIRTH (month, day, and year) March 3, 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	63	7	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) U RY & E.Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER George W. Gorsuch.

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Gosnell.

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co. Md.
(State or country)

14 Informant George W. Gorsuch. (son)
(Address) 2917 Mosher St.

15 Filed ..... 19.....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 25, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Edmondson Car barn. October 25, 1930

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt M. D.

10/27 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Burial

DATE OF BURIAL Oct 29 1930

20 UNDERTAKER W. M. Routson

ADDRESS 2238 E. Monument

important. See instructions on back of certificate.

OCT 27 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61707 46 E 61707

E 61707

REGISTERED NO. 46 168

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Nellie Appleby.

(a) RESIDENCE NO. 2108 N. Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 29, 1885

7 AGE: Years 45 | Months 1 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundry Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

10 NAME OF FATHER: Thomas Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Margaret Costello

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Record

(Address)

15 Filed ..... 19 C. HAMPSON JONES, Registrar

OCT 27 1930 By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to Oct 24, 1930, that I last saw her alive on Oct 24, 1930, and that death occurred, on the date stated above, at 3.50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix. (Squamous epithelioma)

(duration) yrs. 2 ? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Oct. 3, 1930

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Robert W. Arnautt, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 10/27/1930

20 UNDERTAKER: Jos Cook 1217

ADDRESS: St Paul St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61708 E 61707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33[illegible] & Calvert ST., WARD) 9-46

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carlton C. Johnson

(a) RESIDENCE NO. 3052 Mathew St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE~~ of Elsie L. Johnson

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Howard Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records (Address)

15 Filed ....., 19 ..... C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26th, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1930, to Oct. 26, 1930, that I last saw him alive on Oct. 26, 1930, and that death occurred, on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH* was as follows:

~~Nephritis~~

Intra-peritoneal Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis & hypertension & ~~arteio~~-sclerosis (duration) Unknown ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urinalysis, Blood Chemistry.

(Signed) Francis W. Gluck, M. D.

10/26, 1930, (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL 10/29/1930

20 UNDERTAKER Wm. Cook — ADDRESS 1217 St Paul St

1-30—M. & T.—100 B—50L

Roberta S. Hildebrandt ✓

E 61709

HEALTH DEPARTMENT—CITY OF BALTIMORE

167-00 E 61709

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 Penn Lucy Ave ST., 9-47 WARD)

2-FULL NAME Roberta S. Hildebrandt

(a) RESIDENCE NO 731 Penn Lucy Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

6a If married, widowed, or divorced
HUSBAND of William H. Hildebrandt
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14/1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	2	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework at home 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

10 NAME OF FATHER Samuel Kemp

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma V. Hildebrandt

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. H. Hildebrandt
(Address) 731 Penn Lucy Ave

15 Filed OCT 27 1930 C. HAMPSON JONES, M.D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning by asphyxiation
Suicide. (All burners of gas range on)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Joe Kaiser, M. D.
Coroner

, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 10/27/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

E 61710

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61710

45

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSP.) ST. 76-1 WARD)

2-FULL NAME John McCandless

(a) RESIDENCE NO. 1200 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 2-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ire

PARENTS

10 NAME OF FATHER David McCandless

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Kelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Friends

(Address)

Filed OCT 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26/30

17 I HEREBY CERTIFY, That I attended deceased from Sept-14, 1930, to October 26, 1930, that I last saw h~~e~~ alive on October 26, 1930, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the colon

Peritonitis 2nd carcinoma

Bronchopneumonia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 26, 1930

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. H. Campbell M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel cemetery

DATE OF BURIAL Oct 29 19 30

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager st.

Cor.—10-10-29—A Co.—100 Bks.

L 61711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 61711

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 5405 Falls Road St., 27-53 Ward)

2-FULL NAME John Frank Haynie

(a) RESIDENCE NO. 5405 Falls Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella R Haynie

6 DATE OF BIRTH (month, day, and year) Jan 7-1862

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	67	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country) Md

PARENTS

10 NAME OF FATHER John F. Haynie

11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Walker

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country) Md

14 Informant Ella R Haynie
(Address) 5405 Falls Road

15 Filed ... 19... J. HAMPSON JONES, M. D., Registrar

... 1930 Per ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Disease of Heart

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Mossburg M. D.

10/26 1930 (Address) 532 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 27 1930
20 UNDERTAKER	ADDRESS
Hughes & Jones	4248 Broadway

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30 E 61712

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 12-19 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Armstrong

(a) RESIDENCE NO. 420 Worsley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of William Armstrong

6 DATE OF BIRTH (month, day, and year) May 31, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Moody

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nancy Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 2 7 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23-30

17 I HEREBY CERTIFY, That I attended deceased from 2-25-30, 19..., to 10-23-30, 19...,

that I last saw h... in life on 10-23-30, 19...,

and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Actinomycosis of bones of Nose.

(duration) 1½ yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Anaemia, Secondary

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy. Cultures.

(Signed) Paul Podgett, M. D.

10-24, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Oct. 27, 30

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1715 Eutaw

Spec—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 61713

CERTIFICATE OF DEATH.

38

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 61713

1-PLACE OF DEATH Bay View City Hospitals.

CITY OF BALTIMORE: (No. Balto Md. ST. 12-50 WARD)

2-FULL NAME Henry Redd

(a) RESIDENCE NO. 207 E 23rd St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife of~~ Sally Redd

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....no

(b) General nature of industry, business, or establishment in which employed (or employer) laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Redd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va, unk

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records (Address) Balto City Hosp.

15 Filed OCT 27 1930 H. HAMPSON JONES, M. D., Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24-30

17 I HEREBY CERTIFY, That I attended deceased from 1-4-, 1930, to 10-24-, 1930, that I last saw him alive on 10-23-, 1930, and that death occurred, on the date stated above, at √ A. m.

The CAUSE OF DEATH* was as follows:

Lateral Paralysis of Tongue

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Surgical + Clinical findings

(Signed) H. H. Jones M. D.

10 24 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lauel Cemetery — DATE OF BURIAL Oct. 27, 1930

20 UNDERTAKER Mrs. R. G. Elbert — ADDRESS 1725 Eastern Ave

Spec.—1-30—M. & T.—250 Bks.

E 61714

E 61714 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2586 Druid park driveway ST. 15-58 WARD)

2-FULL NAME Mrs. Anna Ballasohn

(a) RESIDENCE NO. 2586 Druid park driveway ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 20 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of Abraham Ballasohn

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Kalman Ballasohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Glazer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Oscar Ballasohn

(Address) 2426 Violet ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27. 30.

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to Oct 27, 1930, that I last saw h er alive on Oct 27, 1930, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis (Cerebral)

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? clinical findings.

(Signed) Michael D. Abrahms, M. D.

(Address) 2360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL North Point Road limit

DATE OF BURIAL Oct 29 1930

ADDRESS 1127 E

20 UNDERTAKER S. Levinson Bro

Baltimore

Spec—1-30—M. & T.—250 Bks

E 61715 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61715

66

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. 23-31 ST. WARD)

2-FULL NAME John. W. Klein.

(a) RESIDENCE NO. 170 W. Cross St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Mary A.

6 DATE OF BIRTH (month, day, and year) May 5, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	52	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 609

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W. Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Anna Rapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Records (Address)

15 Filed OCT 27 1930 C. HAMILTON JONES (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1930, to Oct. 25, 1930, that I last saw him alive on Oct. 25, 1930, and that death occurred, on the date stated above, at 8:33 P. m.

The CAUSE OF DEATH* was as follows:

Psychosis, toxic, alcohol; Hallucinosis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Alcoholism, chronic UNKNOWN

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Town

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History. Exam.

(Signed) Paul Padget, M. D.

10-26 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill. Brooklyn

DATE OF BURIAL Oct 30 1930

20 UNDERTAKER F. A. Kramer

ADDRESS 703 Hanover

Spec.—B 30—A. & Co.—250 Blks

E 61716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-09 E 61716

1 PLACE OF DEATH

CITY OF BALTIMORE: (No 108 W. Lee St 22-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Margaret Fee.

(a) RESIDENCE NO 108 W. Lee ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mns ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 ~~single~~, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10-1850

7 AGE: Years 80 | Months | Days 10 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Edwin Nolan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Budget Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Florence Moran 1725 E. Monument

15 Filed OCT 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24/30

17

I HEREBY CERTIFY, That I attended deceased from 10/22, 1930, to 10/24, 1930

That I last saw h[illegible] alive on 10/24, 1930

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs — mos 4 ds.

CONTRIBUTORY (Secondary) Senile

(duration) yrs. mns. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dan'l Grandeau M. D.

10/26, 1930 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross, Hanford Rd

DATE OF BURIAL: Oct 29 1930

20 UNDERTAKER: F. A. Wanse & Son

ADDRESS: 703 Hamp...

4 Spec.—1-30—M. & T.—250 Bks.

E 61717

241646

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61717

CERTIFICATE OF DEATH.

32

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 20-64 WARD)

2-FULL NAME Walter J. Landgraf Jr.

(a) RESIDENCE NO. 2504 Lehman St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 9 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	child

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Walter

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER June Clivedens†

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Records
(Address)

15 Filed 10/27 1930 C. HAMPSON JONES, M. D.
Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930 to Oct 24, 1930, that I last saw him alive on Oct 24, 1930, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) F. C. Goodwin, M. D.

10/25, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 27th 1930

20 UNDERTAKER E. B. Wyglant

ADDRESS 150 W. Belvedere

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61718

E 61718

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 912 Peach Alley. St. 23-31 (Ward)

2-FULL NAME Annie Brown Scott.(C)

(a) RESIDENCE NO. 912 Peach Alley. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ---mos.---ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, ~~widowed or divorced~~ (or) WIFE of Walter Scott.(C)

6 DATE OF BIRTH (month, day, and year) November 18, 1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69	11	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Archie Brown.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary E. Chew.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mary L. Colbert.(C) sister.
(Address) 2603 Huron St. Mt. Winans.

15 Filed 19 C. HAMPSON JONES, Registrar.

T 271930 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [signature] M. D.

10/25 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemtey

DATE OF BURIAL 10/27 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 139 W. Hoody St.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-203 E 61719

CERTIFICATE OF DEATH

E 61719

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mer Balto Gen Hosp (Street) 16-68 (Ward)

2-FULL NAME Lawrence A Newman

(a) RESIDENCE NO. 2503 N Lavdale St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of fureign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 22-1918

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	12		3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Lawrence C Newman

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Berlin

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Sweden

14 Informant Mr. Lawrence C. Newman
(Address) 2503 N. Lavdale St

15 Filed ..... 19 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ autopsy or inquiry, thereon and from the evidence obtained by said ~~inquest~~, autopsy or inquiry find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:
1 Struck Knocked down
by moving auto
2
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull
(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Edmondson Ave Balto Co

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H L Evans M. D.

10 28 1930 (Address) 2939 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 28 1930
20 UNDERTAKER Henry Hoen & Sons Inc	ADDRESS 1816 E Eager St

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61720 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 61720

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2233 Pelham Ave ST. (WARD) 45

2-FULL NAME Charles J. Franz

(a) RESIDENCE NO. 2233 Pelham Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Katie M. Franz

6 DATE OF BIRTH (month, day, and year) October 30 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer of Badges

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Conrad Franz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Dicker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs. Katie M. Franz.

(Address) 2233 Pelham Ave

15 Filed ..... 19 ..... Registrar

27 1930 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct. 25, 1930, that I last saw h~~e~~ive on Oct 25 1930, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. J. Calhoun M. D.

(Address) 3201 Richard Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Oct. 29 1930

20 UNDERTAKER Henry Hoeck Sons, Inc

ADDRESS 1301 E. Eager St

Spec.—1-30—M. & T.—250 Bks

E 61721

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61721

CERTIFICATE OF DEATH.

75-001

REGISTERED NO. 55-32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2344 Annapolis Rd. St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Stickley

(a) RESIDENCE NO. 2344 Annapolis Rd St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas M. Stickley

6 DATE OF BIRTH (month, day, and year) Jan 31 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Jno King

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Jane Jonesson

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Mrs Mary E Sears

(Address) 2344 Annapolis Rd.

15 Filed OCT 27 1930, 19 THOS. J. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26/30

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to Oct. 26, 1930, that I last saw h[illegible] alive on Oct 26, 1930, and that death occurred, on the date stated above, at 3.P. m.

The CAUSE OF DEATH* was as follows:

Pt. Hemiplegia

7 hrs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension Certain Sclerosis (duration) yrs. 3 mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Howard Kaplan M. D.

10/29/30 (Address) 20 27 N Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 10/29/1930

ADDRESS 1301 E. Eager St.

20 UNDERTAKER Henry Hoeck & Son Inc

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61722

CERTIFICATE OF DEATH

197 E 61722

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 1-24 Ward)

2-FULL NAME James A. Dorsey. (C)

(a) RESIDENCE NO. 1208 McCulloh St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) St. Marys Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Buck Dorsey. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ellen Dorsey. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Estelle Dorsey. (C) sister
(Address) 1208 McCulloh St.

15 Filed C. HAMPTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 22, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Internal hemorrhage due to a pistol shot wound of the back.
Justifyable Homicide.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Stiles & McKechen Sts. Oct 21, 1930

Did an operation precede death? Yes- Date of Oct 22, 1930

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquest.

(Signed) Otto Kenland, M. D.

10/27, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Livia

DATE OF BURIAL 10-27 1930

20 UNDERTAKER Joseph A. Lively, 4077 Fremont Ave

ADDRESS

Important. See instructions on back of certificate.

27 1930

Spec.—1-30—M. & T.—250 Bks

E 61723 ✓ E 61723

E 61723 HEALTH DEPARTMENT—CITY OF BALTIMORE

31

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. 1711 Lancaster st ST. 2-4 WARD)

2-FULL NAME Karol Cerka

(a) RESIDENCE NO. 705 S. Bethel st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Anna Cerka.

6 DATE OF BIRTH (month, day, and ~~year~~) July 18-1892.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	3	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria Poland.

PARENTS

10 NAME OF FATHER Peter Cerka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Poland.

12 MAIDEN NAME OF MOTHER Katherine Sobodine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria Poland.

14 Informant Anna Cerka
(Address) 1711 Lancaster street

15 Filed 2 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27-30

17 I HEREBY CERTIFY, That I attended deceased from Oct-9- , 1930 , to Oct-27- , 1930 ,
that I last saw h— alive on Oct 24- , 1930 ,
and that death occurred, on the date stated above, at 6.15 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis (Laryngeal)

(duration) ..... yrs. 10 mos — ds.

CONTRIBUTORY (Secondary) Nephritis — (duration) ..... yrs. ..... mos. 18 ds.

18 Where was disease contracted if not at place of death? ✓ —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) Frank C Bracco —, M. D.
, 19 (Address) 125 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery October

DATE OF BURIAL 29. 1930

20 UNDERTAKER George A. Weber 705 S Amity st

ADDRESS

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61724

E 61724

CERTIFICATE OF DEATH.

REGISTERED NO. 102

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 604 S. Milton Ave (St.) 1-3 (Ward)

2-FULL NAME Dora Orwig

(a) RESIDENCE NO. 604 S. Milton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Albert H. Orwig

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Anacy Andrzejewsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sofia Kupawa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Albert A. Orwig

(Address) 604 S. Milton Ave.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Oct 26, 1930, that I last saw h[illegible] alive on Oct 25, 1930, and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible], M. D.

10 25 1930 (Address) 2938 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL 10/28 1930

20 UNDERTAKER William Fiaskowski

ADDRESS 618 Eastern Ave

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61725

REGISTERED NO. 90 E 61725

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 May ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Smith

(a) RESIDENCE NO. 1410 May ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Booth Packing co

9 BIRTHPLACE (city or town) (State or country) Md.?

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Sherry Godsey
(Address) 304 N. Eden St

Filed 27 1930, 192 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardio-Renal Disease

(duration) yrs. mos ds. (found dead in bed)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos H Collins Coroner, M. D.

Oct 24, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery DATE OF BURIAL Oct 28 1930

20 UNDERTAKER Chas. H. Johnson ADDRESS 416 N. Carey St

Spec.—1-10-21—MAT—1500 Blks.

E 61726 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61726

CERTIFICATE OF DEATH.

10-60 159-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard + Greene st, ST. 17 WARD)

2-FULL NAME Baby Boy Rhodes

(a) RESIDENCE NO. 2115 Forest Park ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: V ditto

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Allen Stalter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Julian Rhodes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant
(Address)

15 OCT 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/14/30 19

17 I HEREBY CERTIFY, That I attended deceased from 10/13/30, 19 , to 10/14/30, 19 ,
that I last saw him alive on 10/14/30, 19 ,
and that death occurred, on the date stated above, at 4 15 p m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Anomalie

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

19 30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: OCT 27 1930

20 UNDERTAKER: [illegible] Commissioner of Health

ADDRESS

THION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 61727

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61727

CERTIFICATE OF DEATH.

40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST 22-31 WARD)

2-FULL NAME Grant, Emma

(a) RESIDENCE NO. 1st Chance St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	B	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

Filed ....., 19 ..... Registrar

OCT 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21-30

17 I HEREBY CERTIFY, That I attended deceased from 10-19, 1930, to 10-21, 1930, that I last saw h... alive on 10-20, 1930, and that death occurred, on the date stated above, at 6 10 a m.

The CAUSE OF DEATH* was as follows:

Uremia retention Structure of ureters - ruptured ureters urinary extravasation Uremia

(duration) 2 yrs. 2 mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? Yes Date of 10 19 30

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. M. Hundley, M. D.

, 19 (Address) Univ. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL OCT 27 1930

20 UNDERTAKER

ADDRESS

H. HAMPSON JONES, M. D. Registrar

Commissioner Health

UNIVERSITY OF MARYLAND

Spec. 2-29-28—L. F. S.—500 Blks.

E 61728 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 61728

CERTIFICATE OF DEATH

1—PLACE OF DEATH Home for Incurables REGISTERED NO. 43-57

CITY OF BALTIMORE: (No. No 14th St + Kesmick Rd WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary E. Proctor

(a) RESIDENCE NO. Home for Incurables ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 65 yrs. mos. ds. How long in U. S., if foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Proctor

6 DATE OF BIRTH (month, day, and year) Aug. 27 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	9	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Maryland

PARENTS

10 NAME OF FATHER Joseph Scottem

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harlington - Md.

12 MAIDEN NAME OF MOTHER Agnes Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harlington - Md.

14 Informant Records - Home for Incurables

(Address) 40th + Kesmick Rd.

15 Filed OCT 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15 - 1930, to Oct 25 - 1930, that I last saw her alive on Oct 25 - 1931 and that death occurred, on the date stated above, at 8.25 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia -

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? none Patrick

(Signed) J. F. Fleetwood, M. D.

19 (Address) Keswick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct. 27 1930
20 UNDERTAKER	ADDRESS
Margaret E. Flynn	1727 Eutaw Pl.

Spec.—1-30—M. & T.—250 Bks

E 61729

61729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4213 Woodlea Ave ST. 26-41 WARD)

2-FULL NAME Henry Umbach

(a) RESIDENCE NO. 4213 Woodlea Ave WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Dora Umbach

6 DATE OF BIRTH (month, day, and year) June 19 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work painter

(b) General nature of industry, business, or establishment in which employed (or employer) Schluderberg

(c) Name of employer Kunde Co

9 BIRTHPLACE (city or town) (State or country) Germany,

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dora Umbach
(Address) 4213 Woodlea Ave

15 C. HAMPSON JONES, M. D.
Registrar

2 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 5th, 19 30, to Oct 25, 19 30,
that I last saw h— alive on Oct 25, 19 30,
and that death occurred, on the date stated above, at 12.37A mn.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cardiac end of Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Obstruction Cardiac end of Stomach (duration) yrs. 8 mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs, Symptoms + Xray

(Signed) Edw A Benson, M. D.

1926, 1930 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Oct 28, 1930,

20 UNDERTAKER Mrs. Mrs. John H. Tenfelt & Son

ADDRESS 801 N. Fayette St

8pcc—1-30—M. & T.—250 Blks

E 61730

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61730

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 731 Washington Blvd. (ST.) (WARD) 29

2-FULL NAME C. Virginia Albright

(a) RESIDENCE NO. 731 Washington Blvd. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 70				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jesse Albright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louis Mueller
(Address) 731 Washington Blvd.

Filed 2 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1928, to Oct. 25-, 1930, that I last saw h[illegible] alive on Oct. 20, 1930, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Acultatory Tests.

(Signed) J. M. Delevett, M. D.

Oct 27. 1930 (Address) 621 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL Oct 28, 1930

20 UNDERTAKER Wm. J. Tucker & Sons

ADDRESS Mt Pleasant

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61731

E 61731

CERTIFICATE OF DEATH

REGISTERED NO. 181-of 1930

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2309 South Rd. St., Ward

2-FULL NAME Leo John Beeli

(a) RESIDENCE NO. 2309 South Rd. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 9, 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min
	60	0	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Highland
(State or country) Ill

PARENTS

10 NAME OF FATHER John Beeli

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Caroline Blattner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Highland Ill

14 Informant Mrs. Emelia B. Davis
(Address) 2309 South Rd

Filed 19 HAMPSON JONES, M. D.
Registrar

27 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Carcinoma of Pylorus
Coma (Auto)
Accelerator

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Mowsey M. D.

May 27 1930 (Address) 247 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Highland Ill	Oct 28 1930

20 UNDERTAKER Wm H. McKee & Son ADDRESS Catonsville Md

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61732

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61732

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 84 Kenwood ave (St.) 6/10 (Ward)

2-FULL NAME Mary F. Lynch

(a) RESIDENCE NO. 84 N. Kenwood ave ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Lynch

6 DATE OF BIRTH (month, day, and year) May 15 1862

7 AGE — Years 68 — Months 7 — Days 10 — If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Degner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER — Eitman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. G. Mitchell 80 Kenwood ave

15 Filed ____, 19____ C. HAMPSON JONES, M. D. Registrar

271930 Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1930, to Oct 25, 1930, that I last saw her alive on Oct. 25, 1930, and that death occurred, on the date stated above, at 7 30 p m.

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia

(duration) yrs. _____ mos. 3 ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. _____ mos. 1 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) Wm. McNutt, M. D.

Oct 27 1930 (Address) 701 N. Linwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 10/28 1930

UNDERTAKER E. A. Moran

ADDRESS 3000 E Baltimore

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61733

101-001

E 61733

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1029 Bush St. 21-28 (Ward)

2-FULL NAME Ethel Hoffman

(a) RESIDENCE NO. 1029 Bush St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1930

7 AGE	Years	Months	Days	If LESS than 1 day hrs or min.
		8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None old
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Chas A Hoffman

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Grace S Weaver

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Chas A Hoffman
(Address) 1029 Bush

15 Filed 27 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Right Lung

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Brooks, M. D.

Oct 27 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL 10/28 1930

20 UNDERTAKER Harry A Weitzke, 410 — ADDRESS Edmondson Ave

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 61734 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61734

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH Aged Womens Home

CITY OF BALTIMORE: (No. 1404 W Lexington ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Peltz

(a) RESIDENCE No. 1404 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER John ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edna M Turlington

(Address) 1404 W Lexington

Filed 27 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927 to Oct. 26, 1930.

that I last saw her alive on Oct. 25, 1930

and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardio-Vascular-renal disease (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B Jarrell M.D.

, 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Oct 28 1930

20 UNDERTAKER George J Smith ADDRESS 1002 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61735

CERTIFICATE OF DEATH

11-001 ✓ E 61735

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4156 Falls Rd ST. 13-57 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Henry Meyberger

(a) RESIDENCE NO. 4156 Falls Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 11 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Goldey (nee Howeth)

6 DATE OF BIRTH (month, day, and year) Oct. 27, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Department Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Meyberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Goldey Meyberger

(Address) 4156 Falls Road

15 Filed 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1930, to Oct. 26, 1930, that I last saw him alive on Oct. 25, 1930 and that death occurred, on the date stated above, at 7:00 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (Influenza)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) Darius A. Baggett M. D.

10/25 1930 (Address) 2229 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 10/28/30

20 UNDERTAKER: Harry H. Witzke 401 Edmondson

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E. 61736

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 61736

CERTIFICATE OF DEATH

90

REGISTERED NO. [redacted]

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 Annah Ave ST.; 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Schwalm

(a) RESIDENCE NO. 2413 Annah Ave ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Elizabeth Michael

6 DATE OF BIRTH (month, day, and year) Oct. 23-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	-	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor.

(b) General nature of industry, business, or establishment in which employed (or employer) Tailoring Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Schwalm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry E. Schwalm

(Address) 517 Edgewood St.

15 Filed 10-28-1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1930, to Oct. 26, 1930

that I last saw h~~im~~alive on Oct. 26, 1930

and that death occurred, on the date stated above, at 7.25 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination.

(Signed) Frank Brown, M. D.

Oct. 28, 1930 (Address) 1663 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 10/29/1930

20 UNDERTAKER Harry A Witte

ADDRESS 2101 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61737

CERTIFICATE OF DEATH

74-09

E 61732

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 1027 W Fayette ST., (WARD) 18-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Falkini

(a) RESIDENCE NO. 1027 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colrd	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Bettie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Eva Speaks

(Address) 1027 W. Fayette

[illegible] HAMROCK JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1930, to Oct 26, 1930, that I last saw h[illegible] alive on Oct 26, 1930 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis: ✓

(Signed) B. Hamrock Jones, M. D.

10/27/30 (Address) 1027 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary

DATE OF BURIAL Oct 31 1930

20 UNDERTAKER John H Toadvine

ADDRESS 1027 Eutaw Pl

61 32 138

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61738

E 61738

89

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Druid Hill Ave. S. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Pitts

(Residence in Baltimore: No. 1313 Druid Hill Ave. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Single

6-DATE OF BIRTH, Feb-14- 1880, 1 (Month) (Day) (Year)

7-AGE, 42 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): Gp

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Charles Pitts

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Elsie Blundon

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Pitts

(Address) 1313 Druid Hill Ave

15-

Filed....., 191.. H. [illegible] JONES, M. D.

Registrar.

2 of 61738 OCT 28 19

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct — 24th, 1930
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1930, to Oct 24 1930, that I saw h[illegible] alive on Oct 24th 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Empyema Pleura

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Not ascertained

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. H. Mottinger M. D.

Oct 27, 1930. (Address) 1[illegible] E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Zion	Oct 27, 1930
20-UNDERTAKER John H. Goodman	ADDRESS 1127 Druid Hill Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61739

CERTIFICATE OF DEATH

E 61739

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospital

CITY OF BALTIMORE: (NO. ST. 16-23 WARD)

2-FULL NAME James Manta

(a) RESIDENCE NO. 822 N Carrollton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1852.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Yard Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) French West Indies

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Friends (Address) Baltimore City Hosp.

15 Filed Oct 28 1930 19 J. H. McCONDLOUGHES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-25-30

17 I HEREBY CERTIFY, That I attended deceased from 10-24-, 1930, to 10-25-, 1930, that I last saw h— alive on 10-25-, 1930, and that death occurred, on the date stated above, at 6-45 p m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Cerebral Hemiplegia (old)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings

(Signed) Fred M. Dunkenfield, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Oct 28 1930

UNDERTAKER John H. Toadvine

ADDRESS 1027 Hollins St

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 ✓

E 61740

CERTIFICATE OF DEATH

E 61740

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Burgundy Alley ST.) (WARD)

2-FULL NAME Arthur Branch

(a) RESIDENCE NO 212 Emory ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Branch

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 44; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: Harrison Branch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

PARENTS

14 Informant: Mrs. Sarah Branch

(Address) 212 Emory St.

15 Filed 28 1930 192 C. HARRISON JONES, Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No Date of

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Tilford, M. D. Coroner

10/27, 1930 (Address) 239 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lincoln

DATE OF BURIAL: 10/29/1930

20 U. [illegible] UNDERTAKER: E L Brown

ADDRESS: Hope & Monte 88

1-30—M & T —100 B—501.

E 61741

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61741

CERTIFICATE OF DEATH

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 E Balto St.) S. 15-68 WARD)

2-FULL NAME Meyer Caplan

(a) RESIDENCE NO. 2022 N. Bentalou ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Caplan

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk Dept. of Elec. Office
(b) General nature of industry, business, or establishment in which employed (or employer): Ins. Agent
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Caplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Brass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Emanuel Caplan (Son)

(Address) 5910 Pk. Hgts. Ave.

15 Filed 2 1930 19 C. HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Incidental

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Cerebral Hemorrhage~~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1012 E Balto

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? E

(Signed) H. G. Eades, M. D.
Coroner

19 (Address) 112 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lebrun Township — DATE OF BURIAL: 10/28 1930

UNDERTAKER: Jack Lewis — ADDRESS: 1437 E Balto St.

FRONT (Very important. See instructions on back of certificate.)

Spec. 2-29-28 L. F. S. 500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10/001

E 61742

CERTIFICATE OF DEATH

REGISTERED NO. E 61742

1—PLACE OF DEATH West Baltimore Gen. Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. In ST., 16-23 WARD)

2—FULL NAME Major, Pollard

(a) RESIDENCE NO. 1130 Mosher ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Annie B Pollard

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years 40 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Private Family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Va

PARENTS

10 NAME OF FATHER Emmanuel Pollard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Page

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Annie B Pollard (Address) 1130 Mosher St

15 Filed 2-8-1930 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930 to Oct 27, 1930 that I last saw him alive on Oct 27, 1930 and that death occurred, on the date stated above, at 12:45a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory, Clinical

(Signed) H. Cohman, M. D.

10/27/1930 Address) West Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Va DATE OF BURIAL 10/28/1930

20 UNDERTAKER Samuel Brumsey ADDRESS 1178 W Baltimore

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61743

CERTIFICATE OF DEATH.

37-001

REGISTERED NO. E 61743

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2432 Druid Hill Ave (Ward) 13-54

2-FULL NAME C Clayton Smith

(a) RESIDENCE NO. 2432 Druid Hill Av ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs 11 mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 26, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	29	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (City or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Clayton Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Mildred Bowie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant (Address) Mildred Bowie 2432 Druid Hill Av.

15 Filed 2 3 1930 C. HAMPSON JONES, M. D. Registrar

War

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 25 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-12 .1930. to 10-25 .1930.

that I last saw h alive on 10-25 .1930

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis of Lung-

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion & Marasmus

(duration) yrs. mos. 21 (21) ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. P. Hughes, M. D.

10/25 1930 (Address) 825 N. Fremont Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M Woodlawn — DATE OF BURIAL 10/28 1930

20 UNDERTAKER Samuel Bowersky ADDRESS 578 N Carrollton

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 61744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 61744

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Millington ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Jackson

(a) RESIDENCE No. 1605 Millington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown ~~1865~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	87 ~~65~~	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Ed Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Edw Jackson 1323 Myrtle Ave

OCT 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1930, to Oct 26, 1930, that I last saw him alive on Oct 26, 1930, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Chr. Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) John W. Gaines, M. D.

, 19 (Address) 1421 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Unknown

DATE OF BURIAL: Oct 29 1930

20 UNDERTAKER: Samuel Bromley

ADDRESS: 515 N Bond

THIS is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 61745 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61745

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) H 76 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Minnie Hannah Jones Nicholson ST.

2-FULL NAME Hannah Nicholson

(a) RESIDENCE NO. 764 W. Saratoga st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Henry Nicholson

6 DATE OF BIRTH (month, day, and year) Mch. 25, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	6	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 27
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS
10 NAME OF FATHER James Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Lina Owens
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed 19 Registrar

231930 C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1930, to Oct. 24, 1930, that I last saw her alive on Oct. 24, 1930, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:
Acute Pulmonary T.B.
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical & autopsy

(Signed) David Turner, M. D.
10-24-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem
DATE OF BURIAL 10-28 1930

20 UNDERTAKER David Taylor
ADDRESS 916 Park Ave

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61746

CERTIFICATE OF DEATH

90 E 61746

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1446 Rutter ST. 14-20 WARD)

2-FULL NAME John Hawkins

(a) RESIDENCE NO 1446 Rutter ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Hawkins
(Address) 1446 Rutter

15 Filed Oct 22 1930 192 C. HAMPTON JOHNS, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Reynolds

(Signed) H. Schmidt, M. D.
Coroner

, 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 10-28 19 30

20 UNDERTAKER Dent Funeral

ADDRESS 916 E ave

Spec.—1-30—M. & T.—250 Bks

E 61747 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 61747

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ST 18-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Lee Vay

(a) RESIDENCE NO. 906 Boyd St. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jeanette McVay

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte, N.C.

PARENTS

10 NAME OF FATHER William McVay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlotte N.C.

12 MAIDEN NAME OF MOTHER Mary Ann —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlotte N.C.

14 Informant Brother (Address) 923 Boyd St.

15 Filed OCT 28 1930 H. H. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26/30

17 I HEREBY CERTIFY, That I attended deceased from 9/22/30, 19..., to 10/26/30, 19...,

that I last saw h~~e~~ alive on 10/26/30, 19...,

and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) David Tenner, M. D.

10/26/30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Oct 30, 1930

UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3221 Schroeder St.

Spec.—1-30—M. & T.—250 Bks.

24 2E 61748 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61748

CERTIFICATE OF DEATH. × 1-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME Mary Koropsak

(a) RESIDENCE NO. Turners Sta — ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launchess

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Czechoslovakia

PARENTS

10 NAME OF FATHER Jo. Patrovicin

11 BIRTHPLACE OF FATHER (city or town) Chesko Sla. (State or country)

12 MAIDEN NAME OF MOTHER Annie Balbr

13 BIRTHPLACE OF MOTHER (city or town) Chesko Sla. (State or country)

14 Informant Relatives (Address) JOHNS HOPKINS HOSPITAL

15 OCT 28 1930 HAMPSON JOHNS, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1930, to Oct 25, 1930, that I last saw her alive on Oct 25, 1930, and that death occurred, on the date stated above, at 1.5 3P m.

The CAUSE OF DEATH* was as follows:

? Typhoid fever

Immediate: ? Coronary occlusion

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) ? Coronary occlusion (duration) yrs. mos. 2 hrs.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John A. Washington, M. D.

10/25 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer St. Stanislaus — DATE OF BURIAL 10/27/30

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

Spec.—1-30—M. & T.—250 Blks.

E 61749

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 60-001

E 61749

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman Hospital ST., WARD)

2-FULL NAME Maude Gertrude Miller

(a) RESIDENCE NO. Freelands, Maryland ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) August 31, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Freelands, (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac B. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Catherine McAbee

13 BIRTHPLACE OF MOTHER (city or town) Freelands (State or country) Maryland

14 Informant Maude Miller (Address) 727 Belgian Ave. Baltimore Md.

15 Filed OCT 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/30

17

I HEREBY CERTIFY, That I attended deceased from 10/17, 1930, to 10/27, 1930,

that I last saw h(d) alive on 10/27, 1930,

and that death occurred, on the date stated above, at 10:20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hyperthyroidism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 10/22/30

Was there an autopsy? No Thromboplastomy

What test confirmed diagnosis? Clinical evidence

(Signed) Lucian Arnold Gilbert, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middletown Md. Co.

DATE OF BURIAL Oct 30 1930

20 UNDERTAKER Chenoweth Bros

ADDRESS 3615 Chestnut Ave

Spec.—1-30—M. & T.—250 Bks

E 61750 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61750

CERTIFICATE OF DEATH.

13-54 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 902 Whitelock ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs A Carlson

(a) RESIDENCE NO. 902 Whitelock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Eva B. Carlson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Aaron M. Carlson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Eva 1434 Eastern Ave

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927, to Oct 27, 1930,

that I last saw h~~im~~ alive on Oct 27, 1930,

and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis 4 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Findings

(Signed) Wertheimer Fort, M. D.

10/27, 1930 (Address) 20 E. Preston St. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levering Mt. Carmel

DATE OF BURIAL 12-28-1930

ADDRESS

20 UNDERTAKER

ADDRESS Eva Evans, 1434 Eastern Ave

OCT 28 1930 C. HAMPSON JONES, M. D. Registrar

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

61751 + 113 E 61751

CERTIFICATE OF DEATH.

61751

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. W-30 WARD)

2-FULL NAME Charles Greaser.

(a) RESIDENCE NO. Owings Mills ST., Baltimore co Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) July 6 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Owings Mills Balto co Md

PARENTS

10 NAME OF FATHER Robert J. Greaser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Catharine Goldsmith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Mrs Catharine Greaser

(Address) Owings Mills Md

15 FEB 28 1930 H. A. K. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1930, to Oct 27, 1930, that I last saw him alive on Oct 27, 1930, and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Gastro intestinal Malnutrition

(duration) yrs. 2 mos da.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Chas S. Gill, M. D.

Oct 30, 1930 (Address) University Hospital, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Hill

DATE OF BURIAL Oct 30 1930

ADDRESS

20 UNDERTAKER J. F. Eckhardt Reisterstown Md

Spec.—1-30—M. & T.—250 Bks.

E 4200 61752

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 61752

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Howard

(a) RESIDENCE NO. 226 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (strike~~ the word)

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14-1930

7 AGE: Years | Months 5 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Child

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. D

PARENTS

10 NAME OF FATHER Charles Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Madeline Vaughan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19... [illegible] Registrar

C2100 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Oct 25, 1930, that I last saw him alive on Oct 25, 1930, and that death occurred, on the date stated above, at 4 20 p.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea + Entrocolitis.

Acute tonsillitis + pharyngitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J. Campbell Gaughin, M. D.

Oct 26 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery — DATE OF BURIAL: Oct 28 1930

20 UNDERTAKER: Edward Bryan — ADDRESS 1681 Orleans st

1-30—M. & T.—100 B—50L

Stokes

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61753

CERTIFICATE OF DEATH

90 ✓

E 61753

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1048 N. Central Ave ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Joe Stokes

(a) RESIDENCE NO 1048 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Stokes

6 DATE OF BIRTH (month, day, and year) Mar 17/1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co., Md.

PARENTS

10 NAME OF FATHER Joseph Seaborn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co., Md.

14 Informant Mrs. J. J. Kuehnerin

(Address) Summit & Smithwood Aves

15 Filed Oct 30 1930 E. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Insufficiency
(Found dead in bed)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Pacca M. D.
Coroner

Oct 30, 19 30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Oct 29 1930

20 UNDERTAKER George J. Smith

ADDRESS 153 Hollins

02150

Spec.—1-30—M. & T.—250 Bks

E 61754

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61754

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 119 So Toppleton ST.; 18-29 WARD)

2-FULL NAME Owen Harney

(a) RESIDENCE NO. 119 So. Toppleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mary Gallagher.

6 DATE OF BIRTH (month, day, and year) July 6 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machine shop

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Owen Harney.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. Mary Harney.

(Address) 119 So Toppleton St

15 OCT 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26th 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1. 1930. to Oct 26 - 1930.

that I last saw him alive on Oct. 26. 1930.

and that death occurred, on the date stated above, at 1:45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. One (1) mos — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam Etc.

(Signed) J. Chas Norton, M. D.

10/27. 1930 (Address) 888 N. Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 10/29/1930

20 UNDERTAKER John J. Cowan & Son.

ADDRESS 901 Hollins

Spec.—1-30—M. & T.—250 Bks

61755

HEALTH DEPARTMENT—CITY OF BALTIMORE

61755

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 Linden ST. 70-6 WARD)

2-FULL NAME Joseph L. Stencel

(a) RESIDENCE NO. 2123 Linden ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 14th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		3.	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Joseph L. Stencel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Mr Joseph Stencel

(Address) 2123 Linden St.

15 2 8 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/25 1930 to 10/27 1930, that I last saw her alive on 10/27 1930, and that death occurred, on the date stated above, at 6:10 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 10/29/1930

20 UNDERTAKER John J. Cowan & Son

ADDRESS 901 Baltimore St

Spec.—1-30—M. & T.—250 Bks.

E 61756 HEALTH DEPARTMENT—CITY OF BALTIMORE 162 E 61756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline + Eden ST. 21-29 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Conway

(a) RESIDENCE NO. 750 Carroll ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 27th 1930.

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wilmer J Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Evelyn Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr Wilmer J Conway
(Address) 1005 Bush St

15 OCT 28 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-30.

17 I HEREBY CERTIFY, That I attended deceased from 10-27, 1930, to 10-27, 1930, that I last saw h[illegible] alive on 10-7, 1930, and that death occurred, on the date stated above, at 3.54 m.

The CAUSE OF DEATH* was as follows:

a Congenital Atelectasis

(duration) yrs. mos 6 hrs ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

19 (Address) 1103 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore, Md.

DATE OF BURIAL 10/28/1930

UNDERTAKER John J Conway & Son

ADDRESS 90 Hollins St.

Spec.—1-30—M. & T.—250 Bks.

24 61757 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 E 61757

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 15-2 WARD)

2-FULL NAME James Leo Brisco

(a) RESIDENCE NO. 15-32 N. Gilmor ST., St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred SP yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	35	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator man

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Louis Brisco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Francis Case

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 Registrar

OCT 28 1930 C. FRANCIS JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1930, to Oct. 25, 1930, that I last saw him alive on Oct. 25, 1930, and that death occurred, on the date stated above, at 3.47 p m.

The CAUSE OF DEATH* was as follows:

Cause unknown: ? glanders, ? syphilis ? Hodgkins.

Immediate cause circulatory failure

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None.

(Signed) John A. Lanahan, Jr. M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

20 UNDERTAKER Thomas E. Kelson

DATE OF BURIAL Oct 29.30

ADDRESS 1303 Pressman St

Spec.—1-10-21—M&T—1500 Bks.

61758

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61758

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1441 E. Carey ST. 15-23 WARD)

2-FULL NAME James E. Carter.

(a) RESIDENCE NO. 1441 E. Carey. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Isebella J. Carter.

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 50; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St mary Co Md.

PARENTS

10 NAME OF FATHER: Olander. Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Holly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Isebella J. Carter. (Address): 1441 E. Carey St.

15 Filed 19 Registrar

C. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19th 1930. to Oct 26th 1930.

that I last saw ~~him~~ alive on Oct 26th 1930.

and that death occurred, on the date stated above, at 8.30 m.

The CAUSE OF DEATH* was as follows:

Chr. Conec Cyanotic Nephritis.

(duration) yrs. 1 mos 1/2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) Leo St. Langenbach M. D.

(Address) 2215 St. Paul Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catherdal Cemetery

DATE OF BURIAL: Oct 30 1930

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Preston St

TION IS very important. See instructions on back of certificate.

28 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

E 61759

CERTIFICATE OF DEATH

E 61759

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 East Hill ST., 22 WARD)

REGISTERED NO. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ann Faulkner.

(a) RESIDENCE NO. 10 East Hill ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word): Single

6 If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): April 19-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓ ✓ ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Faulkner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Jane Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs John Murray

(Address): 4 N Fremont St

Dated: OCT 28 1930, 19 HARRISON JONES, M.D. Registrar

File

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10.25.30

17 I HEREBY CERTIFY, That I attended deceased from 10.23.30, 19..., to 10.25.30, ..., that I last saw her alive on 10.25.30, 19 P and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) ...yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ...yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

10.26, 1930 (Address) 107 East west St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvert

DATE OF BURIAL: Oct. 29 1930

20 UNDERTAKER: Fred A. Krause Son.

ADDRESS: 703 Hanover St.

Spec.—1-12-23—M&T—500 Blks.

E 61760

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 61760

CERTIFICATE OF DEATH

1-PLACE OF DEATH Hebrew Home for Aged and Infirm REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Belvedere & Greenspring St. 27-54 WARD)

2-FULL NAME David Blumberg

(a) RESIDENCE NO. Belvedere & Greenspring ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 97 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Molly

6 DATE OF BIRTH (month, day, and year) 1833

7 AGE: Years 97 | Months — | Days — | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Latvia

PARENTS
10 NAME OF FATHER Jacob Blumberg
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sigmund Feinblatt Supt. (Address) Belvedere & Greenspring

15 Filed OCT 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27 1930

17 I HEREBY CERTIFY, That I attended deceased from October 20, 1930, to Oct 27, 1930, that I last saw h[im] alive on Oct 27, 1930, and that death occurred, on the date stated above, at 9.5 P m.

The CAUSE OF DEATH* was as follows:
Chr. valvular heart disease (duration) 3 yrs. ... mos ... ds.
CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) ... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H Edmund Kern, M. D.
OCT 27 1930 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run DATE OF BURIAL Oct 28 1930
20 UNDERTAKER Sol Levinson & Bro ADDRESS 11 27 E Balto st

Spec.—1-30—M. & T.—250 Bks.

241854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 61761

E 61761

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 713 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tim Smith

(a) RESIDENCE NO. 812 Shutter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31 - 1930

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
		5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lula Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 28 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930 to Oct 27, 1930, that I last saw him alive on Oct 27, 1930, and that death occurred, on the date stated above, at 12 15 A. m.

The CAUSE OF DEATH* was as follows:

diarrhea + enteritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) J. C. Goodwin M. D.

10/27 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	10-28 1930
20 UNDERTAKER	ADDRESS
Byron Wright	1218 Mc Elderry St

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 61762

CERTIFICATE OF DEATH

E 61762

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Eaythe ST. 5-8 WARD)

2-FULL NAME Infant ~~Wife~~ Hunt

(a) RESIDENCE NO. 1207 Eaythe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Hill

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md. (State or country)

14 Informant Lillian Hunt

(Address) 1207 Eaythe St

15 Filed ... 193 H. M. COOK, Registrar

By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia (Primary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ... Coroner, M. D.

Oct 25 19 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 10-28 1930

20 UNDERTAKER Byrom & Knight 218 N Eutaw St

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

2419 40
61763

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61763

CERTIFICATE OF DEATH.

113

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

2-FULL NAME Paul Harris

(a) RESIDENCE NO. 739 Forrest ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11-1930

7 AGE — Years: — Months: 4 Days: 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: child
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Nathaniel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Tenn

12 MAIDEN NAME OF MOTHER Louise Royal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 5 1930 C. HANSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-27-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1930, to Oct 27, 1930, that I last saw h[im] alive on Oct-27, 1930, and that death occurred, on the date stated above, at 4 40 A m.

The CAUSE OF DEATH* was as follows:

Diarrhea + enteritis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Goodwin, M. D.

Oct 28 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury

DATE OF BURIAL: Oct 29 1930

20 UNDERTAKER: John W Henderson

ADDRESS 1502 E Monument St

Spec.—1-30—M. & T.—250 Bks.

E 61764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 61764

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2813 Alameda Boulevard ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline A. Sellens

(a) RESIDENCE No. 2813 Alameda Boulevard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of [redacted]

6 DATE OF BIRTH (month, day, and year) Aug. 23- 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 968

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Sellens

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary E. Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Miss Harriet Sellens

(Address) 2813 Alameda Boulevard

15 Filed Oct 31 1930 19 C. HAMPSON JONES, M. D. Registrar

231930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/30

17 I HEREBY CERTIFY, That I attended deceased from May 23, 19 30, to Oct 27, 19 30

that I last saw her alive on Oct 19, 19 30,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. 5 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Sanderson, M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cem. Govans

DATE OF BURIAL 10/30 19 30

UNDERTAKER East Side Funeral Home

ADDRESS 1118 N. Wolfe St

Cor.—10-10-29—A Co.—100 Bks.

E 61765

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61765

CERTIFICATE OF DEATH

K

21-31 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 918 Russell St. St., Ward)

2-FULL NAME Charles Bauer.

(a) RESIDENCE NO. 918 Russell St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If ~~married, widowed, or XXXXXX~~ HUSBAND of ~~XXXXXXXX~~ Margaret Bauer

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	69	---		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Amelia Henkes.
(Address) 918 Russell St.

15 Filed OCT 28 1930 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of the heart
Chronic vascular Nephritis (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry

(Signed) Otto M. Reinhardt, M. D.

10/27 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	10/29/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 61766

Dr Carman 1707 N. Carolina St
Ver 2061

E 61766

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Somerset ST. 10-14 WARD)

2-FULL NAME James Waldron Beam

(a) RESIDENCE NO. 1112 Somerset ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Anna M. Beam

6 DATE OF BIRTH (month, day, and year) 4/16/1861

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	69	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 15

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer N. J. Central

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Beam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Gore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anna M. Beam

(Address) 1112 Somerset St

15 OCT 28 1930

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/30

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to Oct 27, 1930, that I last saw him alive on Oct 24, 1930, and that death occurred, on the date stated above, at 9:10 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation, Mitral Murmur, & Edema Limb.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Lung (L) with Infiltration (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopic

(Signed) J. C. Carman, M. D.

10 27 1930 (Address) 1707 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stone Chapel Cemetery — DATE OF BURIAL 10/29/1930

20 UNDERTAKER Wm Cook — ADDRESS 217 St Paul St

Spec—1-30—M. & T.—250 Bks

E 61767 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61767

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 2-4 ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Susie Bernstein Berntsen

(a) RESIDENCE NO. 215 S. Regester ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John

6 DATE OF BIRTH (month, day, and year): Feb. 12, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Albert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Records of Baltimore City Hospitals

15 Filed OCT 23 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-27-30

17 I HEREBY CERTIFY, That I attended deceased from 9-29-30, 19..., to 10-27-30, 19..., that I last saw him alive on 10-27-30, 19..., and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 4 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Gangrene, diabetic, Rt. foot (duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Oct. 8, 1930.

Was there an autopsy? No

What test confirmed diagnosis? exam; lab.

(Signed) Paul Padget, M. D.

10-27-30 19... (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Levantz

DATE OF BURIAL: Oct 30 1930

20 UNDERTAKER: M. W. E. Hepperd

ADDRESS: 332 S Amity

1-30—M. & T.—100 B—501.

E 61768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 61768

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 628 S Bond ST. 24 (WARD)

2-FULL NAME Jacob Bednarczyk

(a) RESIDENCE NO 628 S Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Bednarczyk.

6 DATE OF BIRTH (month, day, and year) July 10 - 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	67	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Paul Bednarczyk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Barbara Braniak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Baltimore City Hospital
(Address) Eastern ave

15 FILED OCT 28 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Broken Down Constitution

(duration) yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? By History

27 (Signed) H. G. Hades, M. D. Coroner

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemtry	Oct. 29 1930

20 UNDERTAKER George A. Weber ADDRESS 700 E Lanvale

CT 28 1930

1-30—M. & T.—100 B—50L

E 61769

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61769

CERTIFICATE OF DEATH

REGISTERED NO. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Penn Ave & Hoffman St., 17-24 WARD)

2-FULL NAME unknown Colored Man

(a) RESIDENCE NO. unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	mulatto

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant N. W. Police Board

(Address)

OCT 28 1930

THE MORGUE SINCE NOVEMBER

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry) and that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH was as follows:

(Homicide)
Hemorrhage due to pistol wound of heart
(duration) yrs. Sudden

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted? Penn Ave & Hoffman
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Regular

(Signed) H. Leroy Smith, M. D. Coroner
(Address) Baltimore

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

OCT 28 1930

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 61770 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61770

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH Balto md

CITY OF BALTIMORE: NO 5510 Narissa Ave ST. 27-55 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Ellen Demmitt

(a) RESIDENCE. NO 5510 Narissa ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S. If of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) aug 16 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	77	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Zepp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant D. J. Shivers
(Address) 5310 Narissa Ave

15 Filed ___, 19 ___ Registrar

2 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct 28, 1930, that I last saw h[er] alive on Oct 25, 1930, and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ___ yrs. ___ mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) ___ yrs. 6 mos. ___ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles Mills, M. D.

, 19 (Address) 3742 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Bridge

DATE OF BURIAL Oct 30 19

20 UNDERTAKER H H Bankard & Son

ADDRESS Westminster

HUNSON JOHNS

Spec.—1-30—M. & T.—250 Bks.

E 61771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162

E 61771

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1651-E. 25th St. ST. 8-45 WARD

2-FULL NAME Joseph Mackain

(a) RESIDENCE NO. 1651-E. 25th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/27/30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	—	—	1—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Mackain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Stafford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Joseph Mackain (Address) 1651-E. 25th St

15 Filed OCT 28 1930 19 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26-30

17 I HEREBY CERTIFY, That I attended deceased from 10-27 19 30 to 10-26 19 30

that I last saw h... alive on 10-27 19 30

and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) [illegible] M.D.

(Address) 800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 10/28/30 19

20 UNDERTAKER Geo. J. Roth Sons

ADDRESS 1731 Hanover

Spec.—1-30—M. & T.—250 Bks

E 61772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 61772

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 2-4 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Anderson

(a) RESIDENCE NO. 425 S. Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Records of Balto. City Hospitals

15 Filed 2-8-1930 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26-30

17 I HEREBY CERTIFY, That I attended deceased from 10-23-30, 19 ..... to 10-26-30, 19 ....., that I last saw him alive on 10-26-30, 19 ....., and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) UNKNOWN yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) UNKNOWN yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Paul Padgett., M. D.

10.27 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL 10/29/1930

20 UNDERTAKER George J. Pentz Inc

ADDRESS 1705 Hoy

Spec.—1-30—M. & T.—250 Bks

E 61773 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-002 ✓ E 61773

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1061 Harford ave ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schneider

(a) RESIDENCE NO. 1061 Harford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 11 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margret Schneider

(Address) 1061 Harford ave

15 Filed OCT 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/5, 1930, to 10/27, 1930, that I last saw h[illegible] alive on 10/26 1930 and that death occurred, on the date stated above, at 10.— A. m.

The CAUSE OF DEATH* was as follows:

Paraplegia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wyatt M. D.

10/27 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Oct. 30 1930

20 UNDERTAKER Henry Hoen[illegible] Sons Inc

ADDRESS 1301 E Eager St

Spec.—1-30—M. & T.—250 Bks

E 61774 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61774

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry George Hunt.

(a) RESIDENCE NO. 1 Selma Ave. Woodbrook Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	—

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 13th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert L. Forest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rose M. Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Howard D. Hunt

(Address) 1 Selma Ave. Woodbrook Md

Filed 28 1930, 19

C. HANSON JONES, M. D.

U. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 27, 1930,

that I last saw h[illegible] alive on Oct 27, 1930,

and that death occurred, on the date stated above, at 9:15 p. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy? No Clinical findings.

What test confirmed diagnosis?

(Signed) Henry George Hunt, M. D.

, 19 (Address) 1 Selma Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 29 1930

20 UNDERTAKER Frank A. Fink

ADDRESS 915 N. Gay St.

Spec.—2-29-28—L. F. S.—500 Bks.

Grace L. Thomas

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61775

90

E 61775

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 160 W. Cross ST. 22-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace L. Thomas.

(a) RESIDENCE NO. 160 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Thomas.

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	11.	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co.

PARENTS

10 NAME OF FATHER John Jett.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arund'el Co.

12 MAIDEN NAME OF MOTHER Margaret Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co.

14 Informant Vinnie T. Thomas

(Address) 160 W. Cross St.

15 Filed ... 19 ... Registrar

2 8 1930 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10. 1927. to Oct. 27. 1930.

that I last saw her alive on Oct. 26, 1930

and that death occurred, on the date stated above, at 2.10 A.m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis and aortic regurgitation of heart

(duration) 3 yrs. 4 mos. 17 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) immediate yrs. mos. ds.

18 Where was disease contracted if not at place of death? a - - -

Did an operation precede death? no Date of - - - -

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) Thos. Keebel M. D.

10/27, 1930 (Address) 1224-1226 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Oct 29, 1930

20 UNDERTAKER E. Edward Evans ADDRESS 30 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61776

REGISTERED NO. 1830 E 61776

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hosp St. 22-30 (Ward)

2-FULL NAME Jos Lenthen Woodfolk

(a) RESIDENCE NO. 602 S Paca St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Woodfolk

6 DATE OF BIRTH (month, day, and year) Feby - 1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer /

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Edw Woodfolk

11 BIRTHPLACE OF FATHER (city or town) /
(State or country) Va

12 MAIDEN NAME OF MOTHER Martha Lenthen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Caldwell Co

14 Informant (Address) William Lenthen 602 S. Paca St.

15 Filed 2 6 1930 O. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: While attempting to board an auto [illegible] to start (Was dead when car was [illegible]

(a) (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lac Lurt

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Iceland or Iowa

Did an operation precede death? yes Date of 10-24-30

Was there an autopsy? no

What test confirmed diagnosis? Clin + Surg

(Signed) I. Frame, M. D.

10 28 1930 (Address) 2939 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 10 29 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 139 W. Lexington St.

Important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 61777

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61777

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 70-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johannes Schlenker

(a) RESIDENCE NO 3602 Benkert Ave or new number 42 S. Benkert Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Karolina Schlenker

6 DATE OF BIRTH (month, day, and year) July 8/1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Karolina Schlenker
(Address) 3602 Benkert Ave

15 Oct 28 1930 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency
(Probably Ventricular fibrilation)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) J. H. Cain, M. D. Coroner

19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 10/29/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks. Dr Ebaugh 700 W. North Ave Mad 0652

E 61778 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2016 Harlem Ave (Street) 16-22 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Hagger

(a) RESIDENCE NO. 2016 Harlem Ave (Street) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of or) WIFE of James S. Hagger

6 DATE OF BIRTH (month, day, and year) March 2 1848

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	82	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah A. Evatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie Hults

(Address) 2016 Harlem Ave

15 FILED 19 Registrar

28 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Oct 27, 1930, that I last saw h~~e~~ alive on Oct 26, 1930, and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Irene Ebaugh, M. D.

Oct 28, 1930 (Address) 700 West N Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 10/29/1930

20 UNDERTAKER Wm Cook

ADDRESS 127 St Paul St

Spec.—1-30—M. & T.—250 Bks.

E 61779 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61779

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 313 S. Payson ST. 20-28 (WARD)

2-FULL NAME Margaret Schaaf.

(a) RESIDENCE NO. 313 S. Payson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Schaaf.

6 DATE OF BIRTH (month, day, and year) June 3rd 1855

7 AGE Years 74 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS
10 NAME OF FATHER Ludwig Mueller
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.
12 MAIDEN NAME OF MOTHER Elizabeth Stritt
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Mueller
(Address) 313 S. Payson St

Filed Oct 28 1930, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26/30

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Oct. 26, 1930, that I last saw h— alive on Oct 12, 1930, and that death occurred, on the date stated above, at 12 O. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio Sclerosis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) yrs. mos. 3 Wks.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. J. Thorn, M. D.
1211, 19 30 (Address) 216 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery | DATE OF BURIAL Oct 29/1930

20 UNDERTAKER J. B. Stewart | ADDRESS 1154 N. Bell St

1-30—M. & T.—100 B—50L

E 61780

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61780

CERTIFICATE OF DEATH

178

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at Hopkins Hospital ST. 6-9 WARD)

2-FULL NAME Herbert Wiltz

(a) RESIDENCE NO 304 N. Dallas ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	singl e

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15/ 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	1	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O[illegible]
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Edward Wiltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eva Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant [illegible] Smith (sister)
(Address) 1639 E. Monument St

15 Filed 28 1930, 192[illegible]

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: 3rd degree burns over entire body House in which he lived caught fire from an accidently overturned lamp.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes by Dr. Waldeis

What test confirmed diagnosis? .....

(Signed) [illegible] Coroner, M. D.

Oct 28/30, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Elm	10-28-30

20 UNDERTAKER Jas. W. Skinner ADDRESS 1625 E. Madison St

Spec.—1-30—M. & T.—250 Blks

E 61781

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61781

37-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals ST., 76-37 WARD

CITY OF BALTIMORE: (NO. .....

2-FULL NAME William Stevs ST., 26 WARD .....

(a) RESIDENCE NO. 434 S. 14th St (If non-resident give city or town and State)

(Usual place of abode) How long in U. S., if of foreign birth? 2 yrs. mos. ds.

Length of residence in city or town where death occurred 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Millwright 046

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Steve

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Celia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Record

(Address) .....

Filed 10 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26/30

17 I HEREBY CERTIFY, That I attended deceased from 10/20/30, 19..., to 10/26/30, 19..., that I last saw h.. alive on 10/26/30, 19..., and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

*Miliary tuberculosis

(duration) yrs. 2 mos ..... da.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) David Penner, M. D.

10/26/30 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Steubenville Ohio

DATE OF BURIAL Oct. 28 1930

ADDRESS 403 S Wood St

20 UNDERTAKER Lilly & Julien Inc

Spec.—1-12 23—M&T—500 Blks.

E 61782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88 E 61782

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 McCulloh ST. 11-24 WARD)

2-FULL NAME Jas H. Johnson

(a) RESIDENCE NO. 818 McCulloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Johnson

6 DATE OF BIRTH (month, day, and year) Sept 19-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	—	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Steamboat Contract

(c) Name of employer Steve C. Conner

9 BIRTHPLACE (city or town) (State or country) Elkridge Howard Co Md

PARENTS

10 NAME OF FATHER Wm Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Fannie Johnson

(Address) 818 McCulloh

Filed OCT 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Oct 25, 1930, that I last saw him alive on Oct 25, 1930, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustav Wahman, M. D.

, 19 (Address) 856 Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Oct 29 1930

20 UNDERTAKER John H. Frazier

ADDRESS 1027 Sandtill

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61783 ✓ × 90 E 61783

E 61783

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST. 12-49 WARD)

2-FULL NAME Henry Crosby Holbrook

(a) RESIDENCE NO. McDonough, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poughkeepsie, N.Y.

PARENTS

10 NAME OF FATHER David Holbrook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winterstown N.Y.

12 MAIDEN NAME OF MOTHER Susan Bartlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winterstown N.Y.

14 Informant Hospital Record (Address)

15 Filed 2 9 1930 C. HILLSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1930, to Oct 27th, 1930.

that I last saw him alive on Oct 27th, 1930,

and that death occurred, on the date stated above, at 12m reading 27th m.

The CAUSE OF DEATH* was as follows:

Vegetative Endocarditis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Richard Trance, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Binny-N.Y. DATE OF BURIAL Oct 30 19 30.

20 UNDERTAKER Stewart & Co ADDRESS Balto

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61784

CERTIFICATE OF DEATH

E 61784

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) En route to Univ. Hosp. ST., WARD

2-FULL NAME Charles Young

(a) RESIDENCE NO. 323 N. Poppleton ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Young

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant

(Address)

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Revolver wound of head

Suicide (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, Coroner, M. D.

10/25 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health

OCT 28 1930

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61735

CERTIFICATE OF DEATH

E 61735

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 W. Lexington ST., 4-16 WARD)

2-FULL NAME John Evans

(a) RESIDENCE NO. 723 W. Lexington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Evans

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grave-digger
(b) General nature of industry, business, or establishment in which employed (or employer) 060
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed 10-29 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D. Coroner

10/28 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

UNIVERSITY OF MARYLAND

DATE OF BURIAL OCT 28 1930

20 UNDERTAKER

Commissioner Health.

ADDRESS

THE MORGUE

E. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 61786 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61786

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 814 Edmondson St. 16-16 (WARD)

2-FULL NAME Hampton Williams

(a) RESIDENCE NO. 814 Edmondson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Addie Williams

6 DATE OF BIRTH (month, day, and year) Feb 21, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Va
(State or country)

PARENTS

10 NAME OF FATHER Geo Williams

11 BIRTHPLACE OF FATHER (city or town) Richmond Va
(State or country)

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Addie Williams
(Address) 814 Edmondson ave

15 Filed 2-9 1930 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Oct 28, 1930, that I last saw h alive on Oct 27, 1930 and that death occurred, on the date stated above, at 12 & 9 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Nephritis (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin.

(Signed) H. Carter, M. D.

19 (Address) 10 Peabody

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem

DATE OF BURIAL 10-28 1930

20 UNDERTAKER Finds Estate

ADDRESS 516 Park ave

Spec.—1-30—M. & T.—250 Bks

E 61787 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61787

CERTIFICATE OF DEATH.

REGISTERED NO. 4-25-90

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Chung Jung Kei

(a) RESIDENCE NO. 211 W. Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Yellow	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundry
(b) General nature of industry, business, or establishment in which employed (or employer) Oth
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 2-9-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-30

17 I HEREBY CERTIFY, That I attended deceased from 10-22-30, 19..., to 10-27-30, 19..., that I last saw him alive on 10-27-30, 19..., and that death occurred, on the date stated above, at 2:25 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic (duration) unknown yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) unknown yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.
10-28 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Com.

DATE OF BURIAL Oct 29, 30

20 UNDERTAKER John F Dennis

ADDRESS 715 Light St

Spec.—1-30—M. & T.—250 Bk

HEALTH DEPARTMENT—CITY OF BALTIMORE

61788

CERTIFICATE OF DEATH.

90 E 61788

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1623 Park Ave ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia C. Turnbull

(a) RESIDENCE NO. 1623 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of A Nisbet Turnbull

6 DATE OF BIRTH (month, day, and year) 9 Feb. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Horatio L. Whitridge

11 BIRTHPLACE OF FATHER (city or town) Compton (State or country) Rhode Island

12 MAIDEN NAME OF MOTHER Elizabeth B. Hall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Horatio W. Turnbull (Address) 1623 Park Ave Baltimore Md.

15 Oct 29 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28-1930

17 I HEREBY CERTIFY, That I attended deceased from April, 1927, to Oct 28, 1930.

that I last saw h. W alive on Oct 19, 1930.

and that death occurred, on the date stated above, at 4.45 Am.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas W. Lamed, M. D.

Oct 29. 1930 (Address) 1327 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount

DATE OF BURIAL Oct 30 1930

20 UNDERTAKER Kenny & Jenkins

ADDRESS McCulloh & Richards Sts.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61789 — CERTIFICATE OF DEATH — +47 ✓ — E 61789

REGISTERED NO.

1—PLACE OF DEATH Home for Incurables (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 40th & Keswick ST 13-5 WARD)

2—FULL NAME Mrs. Mary Thompson Burch

(a) RESIDENCE NO. Leesburg Va ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of — Widow

6 DATE OF BIRTH (month, day, and year) Nov. 24 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Queen Anne's Co
(State or country) Md.

10 NAME OF FATHER Samuel A. Thompson

11 BIRTHPLACE OF FATHER (city or town) Queen Anne's Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Castleman Buchstaff

13 BIRTHPLACE OF MOTHER (city or town) Queen Anne's Co
(State or country) Md.

PARENTS

14 Informant Home Record
(Address)

15 [illegible] 29 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 - 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to Oct 29th, 1930, that I last saw h[illegible] alive on Oct. 28, 1930, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma to pelvis and cranium from Carcinoma of breast - two years before (duration) — yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Physical methods

What test confirmed diagnosis? Mayo

(Signed) [illegible] M. D.

10/29/1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leesburg Va	10/29/1930
20 UNDERTAKER Engle Funeral Home	ADDRESS Leesburg Va

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61790

E 61790

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7-9 WARD)

2-FULL NAME Helen Jubilee

(a) RESIDENCE NO. Turners Station ST., Ind. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1 1930

7 AGE: Years | Months 3 | Days 25 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ind

PARENTS

10 NAME OF FATHER Frank Goday

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind

12 MAIDEN NAME OF MOTHER Minnie Jubilee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) Johns Hopkins Hospital

15 Filed ... HAMPTON JONES, M.D. Registrar

OCT 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26/30

17 I HEREBY CERTIFY, That I attended deceased from October 2 1930, to October 26, 1930, that I last saw her alive on October 26, 1930, and that death occurred, on the date stated above, at 4.20 p m.

The CAUSE OF DEATH* was as follows:

Diarrhea + enteritis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) acute pancreatitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. C. Jacobs M. D.

10/27 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary

DATE OF BURIAL: Oct. 29 1930

UNDERTAKER: Mrs. R. G. Elbert

ADDRESS 1745 Ashland Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61791

CERTIFICATE OF DEATH.

100-201 E 61791

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Sinai Hospital ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Goldstein Sinai Hospital

(a) RESIDENCE NO. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26 1930

7 AGE — Years | — Months | 2 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y

12 MAIDEN NAME OF MOTHER Ida Hurlat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant S. Goldstein

(Address) 1204 N. North ave

Filed 10 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28. 1930

17 I HEREBY CERTIFY That I attended deceased from October 24, 1930, to October 28, 1930, that I last saw him alive on October 28, 1930, and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows:

Hemorhagic disease of the new born

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Charles Gilbert Cohen M. D.

Oct 29, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern ave

DATE OF BURIAL Oct 29, 1930

20 UNDERTAKER Sol Levinson Bro

ADDRESS 127 E Balto st

Spec.—1-30—M. & T.—250 Bks

E 61792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 61792

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 Maugold ST. 21-29 WARD)

2-FULL NAME Baby Boy Brooks

(a) RESIDENCE NO. 806 Maugold ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 27, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, 15 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Walter Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillian Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lillian Brooks

(Address) 806 Maugold St

19 2-9-1930 H. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1930, to Oct. 27, 1930,

that I last saw him alive on Oct. 27, 1930,

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

Uncia

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct. 29 1930 (Address) Essex. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	10/29 1930
20 UNDERTAKER Fred R. Cole	ADDRESS 1200 W Lombard

Spec.—1-30—M. & T.—250 Bks

E 61793

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61793

CERTIFICATE OF DEATH.

REGISTERED NO. 16-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 Maugold ST. 21-24 WARD)

2-FULL NAME Baby girl Brooks

(a) RESIDENCE NO. 806 Maugold ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 27, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or mm.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltmore, Md.

PARENTS

10 NAME OF FATHER Walter Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillian Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lillian Brooks

(Address) 806 Maugold St

Filed 10-29-1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1930, to Oct. 27, 1930, that I last saw her alive on Oct. 27, 1930, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct. 29, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	10/29 1930
20 UNDERTAKER Frank A. Otten	ADDRESS 1220 Fawkins

1-30—M. & T.—100 B—50L

E 61794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001

REGISTERED NO. E 61794

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2935 Hudson ST. 1-1 WARD)

2-FULL NAME Wladyslaw Pszybylowski

(a) RESIDENCE NO. 2935 Hudson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Marie Pszybylowska

6 DATE OF BIRTH (month, day, and year) Aug 7-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md,

PARENTS

10 NAME OF FATHER Wladyslaw Pszybylowsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wilhelmina Lendwicky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wladyslaw Pszybylowsky

(Address) 1922 E. Pratt St

OCT 29 1930 RAMPON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Gas Poisoning Ill

(duration) yrs. mos 6 hrs

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. 6 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History Findings

(Signed) Geo Climax Yates, M. D.
Coroner

19 (Address) 143 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	10/30 19 30
20 UNDERTAKER	ADDRESS
William Fiackowsky	1618 Eastern

-30—M. & T.—100 B—50L

E 61795

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61795

181-001

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 W. Lombard ST. 18-29 WARD)

2-FULL NAME Vincent Stapanauskas

(a) RESIDENCE NO. 831 W. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Rosa Stapanauskas

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 66 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Lithuania

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Joseph Rogers

(Address) 831 W. Lombard St

15 Filed 291930 C. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoned by illuminating gas
Probably accidental death

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zellers, M. D. Coroner

10/28 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 10/30 1930

20 UNDERTAKER: John Gubiauskas — ADDRESS: 1133 S Paca

Spec.—1-30—M. & T.—250 Bks

E 61796 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 61796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 14-20

CITY OF BALTIMORE: (No. ..... St. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marshall Parrett

(a) RESIDENCE NO. 405 Wilson st. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Parrett

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator boy

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Fred Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lydia Parrott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

Filed 2-9-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1930, to Oct. 28, 1930, that I last saw him alive on Oct. 28, 1930, and that death occurred, on the date stated above, at 9.10 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculous bronchopneumonia

(duration) yrs. 11 weeks mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Tenner, M. D.

10-28-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gestring Lane Mt. Auburn

DATE OF BURIAL 10/31/1930

20 UNDERTAKER Mrs. Geo. E. Holland

ADDRESS 1631 Druid Hill

Spec.—1-30—M. & T.—250 Blks.

E 61797 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61797

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Provident Hosp. REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1514 Division ST. 14 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Lane

(a) RESIDENCE NO. 2045 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) About 1863

7 AGE: About 67 years | Months | Days | If LESS than 1 day, hrs. or min.

Unknown

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address)

C. HAMPTON JONES, M. D.

15 10 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/26/, 1930, to 10/26, 1930, that I last saw her alive on 10/26, 1930, and that death occurred, on the date stated above, at 7 45 P.M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency.

Aortic insufficiency

Cardiac decompensation.

(duration) Unknown ds.

CONTRIBUTORY (Secondary) debility (duration) Unknown ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. George Mc Donald, M. D.

10/28 1930 (Address) 900 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 10/29/1930

20 UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS: 1631 Druid Hill

Cor.—10-10-29—A Co.—100 Bks.

E 61798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 61798

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2811 Remington Ave St., 12-51 Ward)

2-FULL NAME William H Gross

(a) RESIDENCE NO. 2811 Remington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josie Gross

6 DATE OF BIRTH (month, day, and year) July 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Ford Comm

9 BIRTHPLACE (city or town)
(State or country) Calvert Co

PARENTS

10 NAME OF FATHER Louis Gross

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Calvert Co

12 MAIDEN NAME OF MOTHER Dosha Ennis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co

14 Informant Mrs. Brown
(Address) 1635 W Lemmon St

15 Filed [illegible] 1930

HARRISON JONES M

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Coronary Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12-2 1930 (Address) 7632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Oct 30 1930

20 UNDERTAKER Emma E Wright ADDRESS 700 Fremont Ave

Spec.—1-30—M. & T.—250 Bks.

E 61799 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61799

CERTIFICATE OF DEATH.

113

REGISTERED NO. 10-15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 Brentwood Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian R. Herring

(a) RESIDENCE NO. 1222 Brentwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): June 16, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	14 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: August L. Herring

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mamie Duty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): August L. Herring 1222 Brentwood Ave

15 File No. 291930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1930, to Oct 28, 1930, that I last saw h.r alive on Oct. 28, 1930, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1222 Brentwood

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jack J. Singer M.D., M. D.

, 19 (Address) 1220 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 31, 1930

UNDERTAKER: Elmer W. Conklin ADDRESS: 924 E. Eager St

Cor.—10-10-29—A Co.—100 Bks.

E 61800

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

182 ✓ E 61800

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Royster's Wharf Fairfield. St., 7-9 Ward)

2-FULL NAME Arthur E.Brice.(C)

(a) RESIDENCE NO. 607 N.Bond St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married XXXXXXXXXXX HUSBAND of XXXXXXXX Virginia Brice.(C)

6 DATE OF BIRTH (month, day, and year) September 12,1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	36	1	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) O'H O
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Horace Brice.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Laura Jordan.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina.

14 Informant (Address) Virginia Brice.(C) wife. 607 N.Bond St.

JOHNS HOPKINS, M. B. OCT 29 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 21, 1930 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a wharf.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt M. D.

10/29 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	10-30 1930
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Madison St

Important. See instructions on back of certificate.

Cof.—10-10-29—A Co.—100 Bks.

E 61801 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61801

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 1821 Westphal St. St., 24-34 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard L. Kirby.

(a) RESIDENCE NO. 1821 Westphal St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, HUSBAND of Elizabeth Kirby.

6 DATE OF BIRTH (month, day, and year) May 30, 1881

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Pipe fitter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William H. Kirby.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Laura V. Maagaha.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Laura V. Kirby. (mother)
(Address) 1821 Westphal St.

15 Filed OCT 29 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26, 1930 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

Accidental Death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & inquest.

(Signed) Otto M. Reinhardt M. D.

10/29 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL 10/29 1930

20 UNDERTAKER J. F. McCully

ADDRESS 130 E Fort

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61802

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 26-37

CITY OF BALTIMORE: (NO. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phoebe Carrigan

(a) RESIDENCE NO. Colgate, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Carrigan

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Sylvamus Hand

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Levinia Cornelius

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address)

15 Filed OCT 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1930, to Oct. 27, 1930, that I last saw her alive on Oct. 27, 1930, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Lemon, M. D.

10-28, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Oct 31st 1930

UNDERTAKER Lilly + Zeiler Inc.

ADDRESS 403 S. Wolfe St

1-30—M. & T.—100 B—50L

E 61803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 61803

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST. 26-2 WARD)

2-FULL NAME George Miethorn (Brother Titus C.SS.R)

(a) RESIDENCE NO 600 S. Conkling ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rev. John A. Selerschmidt

(Address) 600 S. Conkling St

15 Filed ..... 19..... Registrar .....

T 29 1930

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac-Renal Decompensation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Joseph D Walter, M. D.
Coroner

Oct. 28, 1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL Oct 29 19 30

UNDERTAKER [illegible]

ADDRESS [illegible]

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61804

CERTIFICATE OF DEATH.

× 63

REGISTERED NO. E 61804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital STREET (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carrie Poehlmann

(a) RESIDENCE NO. 309 Ingleside Ave STREET Catonsville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Poehlmann

6 DATE OF BIRTH (month, day, and year) Dec 22, 1886

7 AGE Years 44 Months 9 Days 7 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Louis Poehlmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise Bressler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mr Louis Poehlmann

(Address) 309 Ingleside Ave

15 Filed 19 Registrar

JAMESON JONES, M. D.

29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-28 1930, to 10-29 1930,

that I last saw h alive on 10-29 1930,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Addisons disease

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hy almar S Anderson, M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Oct. 31 1930

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 ✓

16 E 61805

REGISTERED NO.

E 61805

PLACE OF DEATH

City of BALTIMORE: (No. 1006 S Paca St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Edyew Leonard

(a) RESIDENCE NO. 1006 S Paca St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Apr 19 1930

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Francis Leonard

11 BIRTHPLACE OF FATHER (city or town): Baltimore Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Christina Cecilia Cadden

13 BIRTHPLACE OF MOTHER (city or town): Baltimore Md

(State or country)

14 Informant: Father E F Leonard

(Address): 1006 S Paca

15 Filed: C. HAMPSON JONES, M. D. Registrar

By

2 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29 th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1930, to Oct 28, 1930, that I last saw h[illegible] alive on Oct 27, 1930, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute dysentery.

(duration) .....yrs. .....mos. 4½ ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted?

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings

(Signed) H. Wade Murphy, M. D.

, 19 (Address) 2147 Highfield Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial: 10-30 1930

20 UNDERTAKER: Bernard C Hart ADDRESS 1000 S Paca St.

very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 61806

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61806

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2502 - Eager St (ST.) 6-12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Brecia

(a) RESIDENCE NO. 2502 - Eager St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sandrino Brecia

6 DATE OF BIRTH (month, day, and year) 7/1/1862

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	68	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mr. Vincent Patrizzi

(Address) 2502 - Eager St

Filed ... 19 ... HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1930, to Oct. 28, 1930,

that I last saw h... alive on Oct. 28, 1930,

and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. Artigiani, M. D.

, 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 1/30/30.

20 UNDERTAKER Geo. J. Rutt & Son

ADDRESS 1131 Hanover

Spec.—9-30—A. & Co.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61807 E 61807

CERTIFICATE OF DEATH.

46

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No 519 N. Central Ave 5-8 WARD)

2. FULL NAME Emma Kenney

(a) RESIDENCE NO. 519 N. Central Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Married

6a If married, widowed, or divorced (or) WIFE of Randolph Kenney

6 DATE OF BIRTH (month, day, and year) Mar. 28, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cape Charles Va

PARENTS

10 NAME OF FATHER: alexander Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Lydia Kellen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Texas

14 Informant: Randolph Kenney
(Address) 519 N. Central ave

15 OCT 29 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1930, to Oct. 26, 1930 that I last saw her alive on Oct. 25, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) (?) yrs. 4 mos. in bed.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Rayner Browne M. D.

, 19 (Address) 1500 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct. 29 1930
20 UNDERTAKER: Mrs J. G. Locke	ADDRESS: 1302 Jefferson

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61808

CERTIFICATE OF DEATH

101-001

E 61808

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2206 Mace. St. 12-51 Ward)

2-FULL NAME Jane Moore

(a) RESIDENCE NO. 2206 Mace St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	C.	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Grafo Moore

6 DATE OF BIRTH (month, day, and year) Autumn 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) S. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Grafo Moore
(Address) 2206 Mace St.

OCT 29 1930

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

10/28 1930 (Address) 2022 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cem	Oct. 29 1930
UNDERTAKER Mrs. R. G. Elliott	ADDRESS 825 Ashland Ave

Important. See instructions on back of certificate.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61809 — X 31 E 61809

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Hinton Ave ST. 47-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Elizabeth Gunther

(a) RESIDENCE NO. Magnolia Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Wm J Gunther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mathilda Farrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J A Freeman

(Address) 524 Hinton Ave

15 Filed 1930 C. HAMPSON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 24 1930, to October 27 1930, that I last saw her alive on October 27 1930 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Toxemia and ~~Endocarditis~~ myocardial failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not applicable

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

19 (Address) 1032 E. 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon M.E. Cemetery	Oct 30 1930
20 UNDERTAKER Howard McComas	ADDRESS Abingdon Md

Spec—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61810

CERTIFICATE OF DEATH.

129 E 61810

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1850 N. Wolfe ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Bunce

(a) RESIDENCE NO. 1850 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lilly E. Bunce

6 DATE OF BIRTH (month, day, and year) November 4th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant to Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER August Bunce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine Balser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs Lilly E. Bunce

(Address) 1850 N. Wolfe St

15 Filed 1/29 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 4th 1930, to Oct 27th 1930, that I last saw h[illegible] alive on Oct 27th 1930, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

arteriosclerosis

(duration) ?, yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Gardner, M. D.

10/28 1930 (Address) 119 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Oct. 30 1930

20 UNDERTAKER Henry Hoeck & Son Inc.

ADDRESS 1301 E Eager St

Spec.—1-30—M. & T.—250 Bks.

2-4-1998
P.d.

16-002 E 61811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61811

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 10-14 (WARD)

2-FULL NAME Henry Marcus

(a) RESIDENCE NO. 837 Harford Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 18 1930

7 AGE: Years — Months 6 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Marcus

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. Carolina

12 MAIDEN NAME OF MOTHER: Gertrude Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

Filed 2 9 1930, 19.. H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-28-30

17 I HEREBY CERTIFY, That I attended deceased from 10-24, 1930, to 10-28, 1930, that I last saw h[illegible] alive on 10-28, 1930, and that death occurred, on the date stated above, at 11⁴⁰ A. m.

The CAUSE OF DEATH* was as follows:

acute bacillary dysentery

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) laryngospasm (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10/24/30

Was there an autopsy? yes Tracheotomy

What test confirmed diagnosis? & autopsy

(Signed) H. G. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem.

DATE OF BURIAL: 10-30 1930

20 UNDERTAKER: Byron Wright 1218 McElderry St

ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 61812 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61812

CERTIFICATE OF DEATH. 11-001

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No.) 15-68 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eliza C. Wootten

(a) RESIDENCE NO. 1640 Bentalou (St Marys Co. Md) ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28 85

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
75	3.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John. adams.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Hewitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Bertha Fenwick. (Address) 1640 Bentalou Ave

15 Filed 29 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28-30

17 I HEREBY CERTIFY, That I attended deceased from 10-24, 1930, to 10-28, 1930, that I last saw her alive on 10-28, 1930 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

contracted la grippe about 2 wks ago which developed into pneumonia.

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Senile changes.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1640 Bentalou Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) G M Baumgardner M. D.

10/31, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetery St Georges St Marys Co Md

DATE OF BURIAL Oct 31 1930

UNDERTAKER J r McKenzie

ADDRESS 2235 W Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61813 — 129 — E 61813

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 639 N Bentlou ST. 16-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank. R. Baudell

(a) RESIDENCE NO. 639 N Bentlou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wally C. Baudell

6 DATE OF BIRTH (month, day, and year) 6-20-55

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Wn. Tel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

10 NAME OF FATHER James L Baudell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Keener

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

PARENTS

14 Informant W. W. Baudell

(Address) 2023 Remore

15 Filed ... 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Oct 28, 1930, that I last saw h[illegible] alive on Oct 28, 1930 and that death occurred, on the date stated above, at 12:50 Noon

The CAUSE OF DEATH* was as follows:

(a) Chronic Nephritis

(b) Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ray O McCreary, M. D.

10/28/30 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Oct 30 1930

20 UNDERTAKER: W M Rountree

ADDRESS: 223 E N Ave

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 61814

REGISTERED NO.

E 61814

1-PLACE OF DEATH

City of BALTIMORE: (No. 1028 W. Barre St. 21-24 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Heiner

(a) RESIDENCE NO. 1028 W. Barre St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredericka Heiner

6 DATE OF BIRTH (month, day, and year) June 4, 1844

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	86	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Heiner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant (Address) Mr. George Heiner 1028 W. Barre St.

291930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Eugene Feldt M. D. (Coroner)

10/29 30. (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Date of Burial Oct 30" 1930

20 UNDERTAKER Joseph B Cox ADDRESS 1003 W. Baltimore St

very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61815

E 61815

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3611 Edmondson ave St.) (Ward) 90-10

2-FULL NAME Olivia G. Toffling

(a) RESIDENCE NO. 3611 Edmondson ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm N. Toffling

6 DATE OF BIRTH (month, day, and year) April 7, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	6	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W. 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Statesville
(State or country) N. C.

PARENTS

10 NAME OF FATHER Bennett

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Olivia Bennett

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Mrs. James H. Toffling
(Address) 3611 Edmondson Ave

Registrar HAMPSON JONES, M. D.

291930 By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to L death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke M. D.

Oct 28, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL 10/30 1930

20 UNDERTAKER H. C. Brauning Son

ADDRESS 1136 Eutaw st

Important. See instructions on back of certificate.

-30—M. & T.—100 B—50L

E 61816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 E 61816

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1604 N. Chapel ST. 8-17 (WARD)

2-FULL NAME Walter David Fick

(a) RESIDENCE NO 1604 N. Chapel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Fick

6 DATE OF BIRTH (month, day, and year) Mar 17/1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	7	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pipe-fitter
(b) General nature of industry, business, or establishment in which employed (or employer) 59
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick, Md.

10 NAME OF FATHER Joseph Fick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick, Md.

12 MAIDEN NAME OF MOTHER Margaret Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick, Md.

14 Informant Kate Fick (wife)

(Address) 1604 N. Chapel St

Oct 29/30

C. HAMPSON JONES, M. D.

1830 Per ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Amputation of Foot

(duration) yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. H. Walker, M. D.
Coroner

Oct 29, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Evangelical Luth. Dorsey Md.

DATE OF BURIAL 10/30 1930

20 UNDERTAKER William Cook

ADDRESS 1278 Paul St

1-30—M. & T.—100 B—50L

E 61817

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61817

CERTIFICATE OF DEATH

27-48 183

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enroute St. Joseph Hospital ST., 27-48 WARD)

2-FULL NAME Robert Francis Macey

(a) RESIDENCE NO 5001 Midwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of July 30/1911

6 DATE OF BIRTH (month, day, and year) July 30, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank Macey

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York, N.Y.

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co., Md.

14 Informant Frank Macey
(Address) 5001 Midwood Ave

15 Filed OCT 29 1930 Registrar

HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrage-Accidentally shot himself with cal rifle, frontal region(left)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [illegible] Coroner, M. D.

Oct 28/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Govans Presb. Cem.

20 UNDERTAKER C. Vernon Lemmon

DATE OF BURIAL 10/30 1930

ADDRESS 7611 Park Heights

Spec.—1-30—M. & T.—250 Bks.

E 61818

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61818

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Forest Hill Apts. ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose A. Gutman

(a) RESIDENCE NO. Forest Hill Apts. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Aaron Gutman

6 DATE OF BIRTH (month, day, and year) April 16, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	46	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Edward Newbauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Joannette Weil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mr. Aaron Gutman

(Address) Forest Hill Apts.

15 Filed 10 29 1930, 19 Registrar HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Oct 28, 1930, that I last saw h[illegible] alive on Oct 28, 1930, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis - chronic nephritis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) uremia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lutz M. D.

Oct 29, 1930 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Riverside Cemetery Bonnelle Park. N.J.

DATE OF BURIAL 10/30/ 1930

20 UNDERTAKER Laird, Sondheim & Son

ADDRESS 1902 Eutaw Place

Spec.—1-30—M. & T.—250 Bks.

2E 291 / 61819

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61819

CERTIFICATE OF DEATH.

REGISTERED NO. 71-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD) 7-4

2-FULL NAME Calvin Evans

(a) RESIDENCE NO. Honaker - Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-7-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va -

PARENTS

10 NAME OF FATHER McKinley Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Stella Earle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va -

14 Informant Records -

(Address)

Filed 10/29/1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 29, 19 30, to Oct. 29, 19 30.

that I last saw him alive on Oct 29, 19 30.

and that death occurred, on the date stated above, at 3067 M.

The CAUSE OF DEATH* was as follows:

Brain Abscess - ?

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Staph - Meningitis

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? Yes Date of 10-6-30

Was there an autopsy? Yes. Negative. Drainage

What test confirmed diagnosis?

(Signed) C. J. Briggs, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Honaker Va

DATE OF BURIAL 10/29/30 19

20 UNDERTAKER Joseph Ahern's

ADDRESS 211 N Bway

Spec.—1-30—M. & T.—250 Bks.

E 61820

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61820

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 N Calvert ST. 12-19 WARD)

2-FULL NAME Nannie Buchanan Meiere

(a) RESIDENCE No 1724 N Calvert ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

6a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Late Capt J Ernest Meiere

6 DATE OF BIRTH (month, day, and year) Sept 25 1841

7 AGE: Years 89 | Months 1 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Annapolis Md

PARENTS

10 NAME OF FATHER: Admiral F. Buchanan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ann Lloyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Miss Meiere
(Address): 1724 N Calvert St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D., City Registrar.
By .....

29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/1, 1930, to 10/28, 1930, that I last saw h[illegible] alive on 10/28, 1930, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial weakness

Sudden failure at last.

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary): Advanced age

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Geo Schubert, M. D.

1930 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St James Annapolis Md

DATE OF BURIAL: Oct 31 1930

20 UNDERTAKER: Hardy & Hardesty & Son Co

ADDRESS: Cathedral & Franklin Sts

1-30—M & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61821

CERTIFICATE OF DEATH

166 E 61821

REGISTERED NO.

1-~~PLACE OF DEATH~~ Residence

CITY OF BALTIMORE: (No. 1216 E Clinton ST. 76-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene. Pucci

(a) ~~RESIDENCE~~ NO. Pleasant St Joseph. Hospital WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl. Pucci

6 DATE OF BIRTH (month, day, and year): Dec 29. 1906

7 AGE: Years 23. Months 10. Days 2. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Joseph Lpd Giovacchino

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Angelina Stellacci

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Carl. Pucci

(Address): 1216 E. Clinton St

15 [illegible] 29 1930 192 [illegible] HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning
(Suicide)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of Oct 27/30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. Hamm, M. D. Coroner

Oct 29 1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 31 1930

20 UNDERTAKER: Wendell & Lippel — ADDRESS: 3rd & Eden

30—M & T —100 B—50L

E 61822

HEALTH DEPARTMENT—CITY OF BALTIMORE

88-103 ✓ E 61822

CERTIFICATE OF DEATH

1-PLACE OF DEATH Johns Hopkins Hosp

CITY OF BALTIMORE: (No. 1419 Bank St., 37 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Salinsky

(a) RESIDENCE NO ~~Johns Hopkins Hosp~~ STREET ~~Ward~~ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 1 mos. Born in Balt Md How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

3 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Child of School

DATE OF BIRTH (month, day, and year): July 25, 1920

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	3	4	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Mt. Washington

10 NAME OF FATHER: Michael Salinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Kidi

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

Informant: Michael Salinsky

(Address): 1419 Bank St

9 1930 (10 Mar) HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/27/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Child ran into path of moving auto

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lough & Bow'y

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis? Dr Faure

(Signed) ..... M. D. Coroner

10/29 1930 (Address) 1939 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 29 1930

20 UNDERTAKER: Wendell J Ruppel — ADDRESS: 300 N Eden

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61823

CERTIFICATE OF DEATH.

129 ✓ E 61823

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 E. 21st ST. 9-Ho WARD)

2-FULL NAME Mr James William Edgar Selway

(a) RESIDENCE NO. 720 E 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ mary anna Selway

6 DATE OF BIRTH (month, day, and year) April 16 1858

7 AGE: Years 72 Months 6 Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wye Mills, Md.

PARENTS

10 NAME OF FATHER Wm Selway

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Mary Virginia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Mrs Mary Selway 720 E 21st St

15 [illegible] 19 [illegible] Registrar

30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to Oct 27th, 1930, that I last saw h~~im~~ alive on Oct 27th, 1930, and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Chr Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur C Monninger M. D.

(Address) 800 E North Ave.

Oct 28, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Oct 30 1930

20 UNDERTAKER: Mary M. Redfern

ADDRESS: 301 E 22nd

Spec.—1-30—M. & T.—250 Bks.

E 61824 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61824

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 623 Fewell ST. 14-20 (WARD)

2-FULL NAME Clara Johnson.

(a) RESIDENCE NO. 623 Fewell ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): W

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John W. Johnson

6 DATE OF BIRTH (month, day, and year): May 27- 876

7 AGE — Years: 53 — Months: 5 — Days: 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045
(c) Name of employer: Calvert & Co

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Oliver Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: John W. Johnson
(Address): 623 Fewell St.

15 Date Received: OCT 30 1930 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1930, to Oct. 29, 1930, that I last saw h[illegible] alive on Oct. 29, 1930, and that death occurred, on the date stated above, at 3.20A m.

The CAUSE OF DEATH* was as follows:

I
Auto Toxemia
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) Geo H. Tompkins M. D.

10/29/30 (Address) 1012 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Oct 31, 1930

UNDERTAKER: Wm H Chase Son

ADDRESS: 1400 Madison

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

61825

166 ✓ E 61825

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 8-11 WARD)

2-FULL NAME Karl Dittmar

(a) RESIDENCE NO 1203 Linwood Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Anna Dittmar

DATE OF BIRTH (month, day, and year) Dec 1/1868

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	10	26	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) 013
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Johann Dittmar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Diedel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Emma Wilkinson (daughter)

(Address) 1203 Linwood Ave

Filed 192 H. M. Fiske Jones, M. D. Registrar

30 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct27/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Phenol Poisoning (Suicide)

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? yes at Hopkins Hospital

What test confirmed diagnosis? .....

(Signed) J. S. H. Cain, M. D. Coroner

Oct 30/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 10/30 1930

20 UNDERTAKER Philip Herring

ADDRESS 2016 Calvert St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

J 103
188

E 61826

REGISTERED NO. E 61826

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 25-12 Ward)

2-FULL NAME Charlotte Louise Tribull

(R) RESIDENCE NO. 1944 Sponson St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anthony Tribull

6 DATE OF BIRTH (month, day, and year): February 12, 1850

7 AGE — Years: 70 — Months: 8 — Days: 16 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER Louis Kurst

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mr. Charles L. Hawk

(Address) 1913 Breitwert Ave.

15 Filed OCT 30 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Walked from curb into path of moving Auto

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Fractured Contusion Chest

(duration) yrs. mos. ds.

(Signed) H. Frank M. D.

(Coroner)

10 29 30 (Address) 2939 McElderry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.. mos.. ds. In the State yrs. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

Date of Burial: Oct. 31st 30

UNDERTAKER: Dep[illegible] Co.

ADDRESS: 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61827 — 74-001 — E 61827

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3009 Portman ST. 16-67 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lottie Biddison

(a) RESIDENCE NO. 3009 Portman ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. T. Biddison

7 DATE OF BIRTH (month, day, and year) May 16, 1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salt Lake Utah

10 NAME OF FATHER Henry Kriegsmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Tesch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Biddison

(Address) 3009 Portman St.

Filed 30 1930 WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29/30

17 I HEREBY CERTIFY, That I attended deceased from October 17, 1930, to Oct 29, 1930, that I last saw her alive on Oct. 28, 1930 and that death occurred, on the date stated above, at 5.10 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Cerebellum

(duration) 0 yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion (duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) J. M. Delcastle M. D.

Oct 30 1930 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Oct 31 1930

20 UNDERTAKER Geo. H. Little — ADDRESS 2750 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61828

90 E 61828

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 S. Chapel ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank M. Schmitt

(a) RESIDENCE NO. 13 S Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Catherine Schmitt

7 DATE OF BIRTH (month, day, and year) Oct 19-1862

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Rooster

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer N. M. Wagner

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John G Schmitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Mennigh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Schmitt

(Address) 13 S. Chapel

15 Filed 1930 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Oct 24, 1930, that I last saw him alive on Oct 24 1930 10 P m. and that death occurred, on the date stated above, at 9 — P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Arterio Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Gordon M. D.

10/24 1930 (Address) 1139 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 3 1930
20 UNDERTAKER	ADDRESS
Jos. J. Herr	1569 Ingram

Spec.—1-30—M. & T.—250 Bks.

E 61829 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61829

100-004

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 26 N. Lafayette St. 12-20 (WARD)

2-FULL NAME Bernice Patterson

(a) RESIDENCE NO. 26 N. Lafayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 27 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John Patterson

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Sadie Brown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14 Informant Georgie Brown

(Address) 26 N. Lafayette

Filed Oct 30 1930 WALKER JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 1930 to Oct 28 1930

that I last saw her alive on Oct 28 1930

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

A Bronchopneumonia

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exs.

(Signed) Dr. Garland Mitchell, M. D.

Oct 30 1930 (Address) 1134 Dumbarton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville

DATE OF BURIAL 10-30 1930

ADDRESS 916 Cross

20 UNDERTAKER David Taylor

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61830 100-001 E 61830

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1467 Boarman Ave. 15-63 WARD)

2-FULL NAME Charles Cabe

(a) RESIDENCE NO. 1467 Boarman ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Ann Cabe

6 DATE OF BIRTH (month, day, and year) April 22, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen'l Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Cabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mrs. Cabe (Address) 1467 Boarman Ave

15 Filed 30 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927 to Oct. 29, 1930

that I last saw h~~im~~ alive on Oct. 29, 1930

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis - Agitans -

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Joseph W. Hartzky, M. D.

, 19 (Address) 1267 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Friendship Cem

DATE OF BURIAL 10/31/1930

20 UNDERTAKER David Landsman Sons

ADDRESS 1711 Eutaw Place

Spec.—1-10-21—M&T—1500 Blks.

E 61831

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61831

46

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Hanover St. ST. 23-31 WARD)

2-FULL NAME Augusta Schmidt.

(a) RESIDENCE NO. 1307 Hanover St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 28, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	65	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Schmidt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Augusta Fendt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles Schmidt.(brother)

(Address) 1307 Hanover St.

15 30 1930 C. MARVIN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from October, 1929, to October 29, 1930,

that I last saw her alive on October 28, 1930

and that death occurred, on the date stated above, at 4.55 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of August 1930

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto K. Reinhardt MD, M. D.

10/29/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 11/1 1930

20 UNDERTAKER L. F. McCully

ADDRESS 130 E Fort

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61832 ✓ E 61832

E 61832

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No. 100 Caton Avenue St. 7-4-33 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John Cayer

(a) RESIDENCE NO. 627 Hanover St. ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud E. Cayer.

6 DATE OF BIRTH (month, day, and year) 2-2-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56 yrs	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Alcohol plant.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Quebec

PARENTS

10 NAME OF FATHER Frank Cayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Quebec

12 MAIDEN NAME OF MOTHER Maud Julian

13 BIRTHPLACE OF MOTHER (city or town) Bay City (State or country) Mich. U.S.

14 Informant Jenkins Memorial Hospl. (Address) 100 Caton Ave.

15 [illegible] 1930 G. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24 1930

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1930, to October 24, 1930, that I last saw h[illegible] alive on October 24, 1930 and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rt Cheek

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No. —

What test confirmed diagnosis? —

(Signed) Robt Bevan, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 10/31 1930

20 UNDERTAKER J. F. McCully

ADDRESS 1306 Fort

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61833

E 61833

CERTIFICATE OF DEATH

REGISTERED NO. 16001

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1313 Lafayette ave St. 623 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lafayette Irvington Smith

(a) RESIDENCE NO. 1313 Lafayette ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Infant

a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Oct. 7. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant —

(b) General nature of industry, business, or establishment in which employed (or employer) Premature 7 Mos

(c) Name of employer Fortney

9 BIRTHPLACE (city or town) 1313 Lafayette

(State or country)

10 NAME OF FATHER Raymond Daniel Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Marguerite Boyd

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Catherine M. Smith

(Address) 1313 Lafayette ave

15 OCT 30 1930 H. [illegible] Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Oct 29, 1930, that I last saw h[illegible] alive on Oct 29, 1930 and that death occurred, on the date stated above, at 6.55 A. m.

The CAUSE OF DEATH* was as follows:

Premature, Birth

7 Month Fortus (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History —

(Signed) Wm. H. Wright, M. D.

Oct 30, 1930 (Address) 1209 Orsbtman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Oct 30 1930

20 UNDERTAKER Thomas E Nelson.

ADDRESS 1303 Pleasant.

Spec.—1-30—M. & T.—250 Bks

E 61834 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61834

31 v

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (36) REGISTERED NO.

CITY OF BALTIMORE: (NO. 18-Mo ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mable Stokes

(a) RESIDENCE NO. 810 N. Mulberry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Stokes

6 DATE OF BIRTH (month, day, and year) 12/23/1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Fred Sedgwick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records.

15 Filed OCT 30 1930 HAMILTON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26/30

17 I HEREBY CERTIFY, That I attended deceased from 2/5/30, 19..., to 10/26/30, 19..., that I last saw h[illegible] alive on 10/26/30, 19..., and that death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows

Pulmonary Tuberculosis

(duration) 1 yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Tanner, M. D.

10/30/30 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

OCT 30 1930

UNIVERSITY OF MARYLAND Department of Public Health

Spec.—8-16-29—L. F. S.—100 Bks.

E 61835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 61835

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 N Port ST., 1-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Pohl

(a) RESIDENCE NO. 713 N Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Pohl

6 DATE OF BIRTH (month, day, and year): February

7 AGE — Years: 65 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Morocco

PARENTS

10 NAME OF FATHER: Charles Pohl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Morocco

12 MAIDEN NAME OF MOTHER: Frances Watrous

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Morocco

14 Informant: Frances R. Pohl

(Address): 713 N Port St

15 Filed: Oct 30 1930 — WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to Oct 29, 1930, that I last saw h in alive on Oct 29, 1930 and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Sputum & X Ray

What test confirmed diagnosis?

(Signed) Louis Krause M. D.

, 19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 31 1930

20 UNDERTAKER: Funk Bros for 1900 Eastern — ADDRESS

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61836

CERTIFICATE OF DEATH.

REGISTERED NO. E 61836

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Union Memorial Hospital (ST.) 12-49 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ryan

(a) RESIDENCE NO. 1 E 39th ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or WIFE of Mrs Henry Ryan

6 DATE OF BIRTH (month, day, and year) Nov 25, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Manager Oil
(b) General nature of industry, business, or establishment in which employed (or employer) Manf Financial Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Charles Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER M. A. McCord

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Juliet B. Ryan (Address) 1 E. 39th St

Filed OCT 30 1930 HAMPSON JOHNS, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1930, to Oct 29, 1930, that I last saw h(e) alive on Oct 29, 1930, and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:
Hemorrhage into Intestinal Tract

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer
(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. Pitts Pyle, M. D.
10/31, 1930 (Address) 7812 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va.
DATE OF BURIAL Oct 31 1930

20 UNDERTAKER John Ortel Lull Sons
ADDRESS 1600 Eutaw Place

Spec.—1-30—M. & T.—230 Bks.

E 61837

E 61837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 33rd & Calvert ST. 12-47 WARD)

2-FULL NAME Robert A. Rouse

(a) RESIDENCE NO. St. Paul & 34th ST., Cambridge Md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Nellie V. Rouse

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesmanager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Blackhead Rouse (d)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Sherwood (d)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Nellie V. Rouse

(Address) Cambridge Md.

OCT 30 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1930, to Oct. 28, 1930, that I last saw him alive on Oct. 28, 1930, and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardio-vascular-renal dis., Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Pt. + Blood chem.

(Signed) Francis V. Gluck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Finding Park Cemetery DATE OF BURIAL Oct 30 1930

20 UNDERTAKER Jesse Outterbridge ADDRESS 1911 Eutaw Pl

Spec.—8-16-29—L. E. S.—100 Bks.

E 61838

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61838

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 20-27

CITY OF BALTIMORE: (No. 210 N.Fulton Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura J. Cook

(a) RESIDENCE NO. 210 N.Fulton Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George P. Cook

6 DATE OF BIRTH (month, day, and year) Dec.2.1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Wm. S.Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen J. Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wm. R. Cook

(Address) 511 N. Pulaski St.

OCT 30 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29. 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1930, to Oct. 29, 1930, that I last saw h[e/r] alive on Oct. 28, 1930 and that death occurred, on the date stated above, at 1.20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

over 6 weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry L. Offit, M. D.

10-29, 1930 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 31 1930
20 UNDERTAKER	ADDRESS
Law Offutt & Sons	1300 Eutaw St.

30—M. & T.—100 B—50L.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61839

CERTIFICATE OF DEATH

129 E 61839

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3028 Baker St. 16-67 WARD

2-FULL NAME Mary E. Wood

(a) RESIDENCE NO. 1636 Ellamont Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

If married, widowed, or divorced: HUSBAND of (or) WIFE of: Chas T.

DATE OF BIRTH (month, day, and year): Jan 25-1864

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	4	4	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Frederick Md.

10 NAME OF FATHER: Joshua H Jayne

11 BIRTHPLACE OF FATHER (city or town): Frederick (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Baker

13 BIRTHPLACE OF MOTHER (city or town): Frederick (State or country): Md.

Informant: Mary Bayne

(Address): 3028 Baker St

Filed: 30 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) Autopsy thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to (death) on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) H. H. Slack, M. D. Coroner

(Address) 1227 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Nov 1 1930

20 UNDERTAKER: George J Smith

ADDRESS: Wallis

Spec.—1-30—M. & T.—250 Bks

E 61840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 61840

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 N. Luzerne ST.) (Ward 10)

2-FULL NAME Mary J. Kennard

(a) RESIDENCE NO. 100 N. Luzerne ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of George W. Kennard

6 DATE OF BIRTH (month, day, and year) Jan 1, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James J. Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary E. Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant John R. Kennard

(Address) 100 N. Luzerne

15 [illegible] HAMPSON JONES, M. D. Registrar

30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to Oct 29, 1930,

that I last saw h[illegible] alive on " 29, 1930,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 1 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) C. S. Mears, M. D.

10/31/30 (Address) 405 S. Patterson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL Nov 1, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3100 E. Balto St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 61841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 61841

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Calverton Rd. & Franklyn St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Baptista

(a) Residence No. House of the Good Shepherd. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1849

7-AGE 81 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED 065

(a) Trade, profession, or particular kind of work Religious of the Good Shepherd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Ireland

PARENTS.

10-NAME OF FATHER. Peter Hanley

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER. Mary Lannon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Sister of St. Catherine's (Address) Calverton Rd & Franklin St.

15- Filed OCT 30 1930 HAMPDEN JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10/29/30

17- I HEREBY CERTIFY, That I attended deceased from 10/1 29 19 to 10/29 19 30

that I last saw her alive on 10/29 19 30

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

Chronic Endarteritis Syphilis

General Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Examination

(Signed) J. T. Dunn M. D.

10/30 1930 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery DATE OF BURIAL. Oct. 31 1930

20-UNDERTAKER. ADDRESS George L. Schmidt 2101 Eutaw St.

30—M. & T.—100 B—50L

E 61842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓ E 61842

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2900 Overland Ave ST. 27-41 WARD)

2-FULL NAME Owen M. Taylor

(a) RESIDENCE NO 2900 Overland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alma Taylor

DATE OF BIRTH (month, day, and year) Dec 16, 1851

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10	13	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Policeman
(b) General nature of industry, business, or establishment in which employed (or employer) 61
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Annapolis Md

10 NAME OF FATHER Owen M. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ireland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Francis Taylor
(Address) 2900 Overland Ave

Filed ..... 1930 G. HAMPSON JONES, M. D. Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage-Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt Cullen, M. D.
Coroner

Oct 30/30 (Address) 504 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Oct 31, 19 30.

20 UNDERTAKER Mr & Mrs. J. W. Tempel & Son

ADDRESS 631 N. Fayette

Spec.—1-30—M. & T.—250 Bks.

E 61843

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61843

CERTIFICATE OF DEATH.

90

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3513 Newland Road ST., 12 WARD)

2-FULL NAME Charles August Volkmar

(a) RESIDENCE NO. 3513 Newland Rd ST., 12 WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? 75 yrs. 3 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced, HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July-24-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mer

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George Volkmar

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Sommerlad

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Germany

14 Informant Mrs Chas. Sommerlad-(Fernside) (Address) Wm. N. Dallon-Atty

15 OCT 30 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29-30

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1927, to Oct 29, 1930, that I last saw him alive on Oct 29, 1930, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - 3 yrs duration.

→ Primary cause Bronchopneumonia (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. Hampson Jones M. D.

1930, 1930 (Address) 705 Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Oct 31 1930

20 UNDERTAKER Stewart & Co — ADDRESS Balto.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 61844

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61844

CERTIFICATE OF DEATH.

91-002

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3222 Auchentroily Ter St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Gillen

(a) Residence No. 3222 Auchentroily Ter St., ... Ward .....

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Femal

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 15, 1863

7-AGE 67 yrs. 2 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Seamstress

(b) General nature of Industry, business, or establishment in which employed (or employer): Woolf Co

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country): Balto, Md.

PARENTS

10-NAME OF FATHER: John Gillen

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Margaret Cullen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant) Mrs Annie Bagley

(Address) 3222 Auchentroily Ter.

15- Filed 30 1930 G. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 29, 1930

17- I HEREBY CERTIFY, That I attended deceased from Oct 18, 1930 to Oct 29, 1930

that I last saw h. alive on Oct 29, 1930

and that death occurred, on the date stated above, at 5 05 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) yrs. 1 mos. ds

CONTRIBUTORY (Secondary) terminal pneumonia

(Duration) yrs. mos. 3 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Isaac T. Lupp M. D

19 (Address) 30 E Lanvale Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Helena Cemetery DATE OF BURIAL: Oct 31 1930

20-UNDERTAKER: H. S. Marshall ADDRESS: 239 Fallsway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61845

CERTIFICATE OF DEATH

57 E 61845

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3132 Berkshire Road ST. 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME IDA G. ERIKSSON

(a) RESIDENCE NO. 3132 Berkshire Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Eriksson

6 DATE OF BIRTH (month, day, and year) July 22, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Abo
(State or country) Finland

10 NAME OF FATHER - Nordling

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Finland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Finland

14 Informant Miss Helen Eriksson (Daughter)
(Address) 3132 Berkshire Road.

15 10-30-1930 (A. HAMPSON JONES, M.D.)
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13th, 1927, to Oct 29th, 1930, that I last saw her alive on Oct 29th, 1930, and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) K. L. Gordy M. D.

10-30 1930 (Address) Harford Rd & Cleveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Parkwood Cemetery

DATE OF BURIAL
Oct. 31. 1930

20 UNDERTAKER
Henry Sander & Sons, Inc.

ADDRESS
BALTIMORE ST. & BROADWAY.

Spec.—1-30—M. & T.—250 Bks

E 61846 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61846

CERTIFICATE OF DEATH.

REGISTERED NO. 118

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. ..... ST. 27-Hut WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Schieve

(a) RESIDENCE NO. 5320 Anglesea Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lydia Schieve

6 DATE OF BIRTH (month, day, and year) March 18-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Schieve

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mercy Hospital Record
(Address)

Filed 10-30-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930, to Oct 30, 1930, that I last saw him alive on Oct 30, 1930, and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/25/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Robert, M. D.

10/30, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct. 1, 1930

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore St. & Broadway

Spec.—1-30—M. & T.—250 Bks.

E 61847 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61847

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

2-FULL NAME Kathleen Grace Mrs. Joseph M. Woods

(a) RESIDENCE NO. Phoenixville, Penn. ST., Main 143 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mr. J. M. Woods

6 DATE OF BIRTH (month, day, and year) May 6, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER James R. Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Agnes Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Husband

(Address) Same as above

15 Filed 1930 19 A. HAMPSON JONES Registrar

By ADR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30/30

17 I HEREBY CERTIFY, That I attended deceased from 10-21, 1930, to 10-30, 1930, that I last saw h[illegible] alive on 10-30, 1930, and that death occurred, on the date stated above, at 12:35 P m.

The CAUSE OF DEATH* was as follows:

Ca Mammary plus Shock - following surgical Operation

(duration) yrs. 4 mos ? ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 10-30-30

Was there an autopsy? no

What test confirmed diagnosis? - X-Ray + Operation

(Signed) Richard T Shackelford M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phoenixville Pa DATE OF BURIAL 10/30/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

E 61848 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 61848

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 26-27 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Beecher

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Sophia Riddle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 30 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29-30

17 I HEREBY CERTIFY, That I attended deceased from 8-2-29, 19, to 10-29-30, 19, that I last saw her alive on 10-29-30, 19, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic; with aortic insufficiency

(duration) yrs. UNKNOWN mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

(Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 11/1 19 30

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

THOMPSON JONES

Registrar

Spec.—1-10-21—M&T—1500 Blks

E 61849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 61849

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4546 Keswick Rd ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Monroe Nunneberg.

(a) RESIDENCE NO. 4546 Keswick Rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 10, 1913

7 AGE: Years 17 Months 3 Days 13

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. County

9 BIRTHPLACE (city or town) (State or country) Balto. County

PARENTS

10 NAME OF FATHER Otto F. Nunneberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Elizabeth Rehbein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mother

(Address) .....

15 30 1930

16 Registrar H. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1930 to Oct. 30 1930.

that I last saw him alive on Oct. 24 1930.

and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma left femur

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Metastatic pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 11, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) Earl S. Benson, M. D.

19 (Address) 5111 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harford Presbyterian

DATE OF BURIAL 11/2 1930

20 UNDERTAKER H. H. Cook

ADDRESS 1217 E. Pratt St.

Spec. 2-29-28—L. F. S.—500 Blks.

E 61850

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61850

CERTIFICATE OF DEATH

38

REGISTERED NO.

1—PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. ST. 5-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street number.)

2—FULL NAME David Williams

(a) RESIDENCE NO. 3114 W North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of: Irene E Williams

7 DATE OF BIRTH (month, day, and year): Aug. 9. 1885

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: Hessinger Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: David E Williams Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lillie Chalk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Irene E Williams

(Address) 3114 W North Ave

15 Date: 1930 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/21, 19 30, to 10/30, 19 30

that I last saw him alive on 10/21, 19 30

and that death occurred, on the date stated above, at [redacted]

The CAUSE OF DEATH* was as follows:

Chronic Glomerulo nephritis with Terminal Uraemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Syphilis C.N.S.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab & Clinical

(Signed) H Leahman, M. D.

19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 11/4 1930

20 UNDERTAKER: E M Cook

ADDRESS: 1219 E Pratt St

Spec.—9-30—A. & Co.—250 Blks

E 61851 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61851

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE (No.) 1619 Caroline St. 8-17 (WARD)

2. FULL NAME Katie E. Krause

(a) RESIDENCE NO. 1619 Caroline St. WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Krause

6 DATE OF BIRTH (month, day, and year) Sept 17, 1853

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
77	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Conrad Unkelbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Stander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Geo. E. Krause 1619 N. Caroline St.

15 Filed 10 1930, 19 J. HAMPSON JONES, Registrar

Plat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1930, to Oct 29, 1930

That I last saw her alive on Oct 29, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Decalcification of bones

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) chronic valvular disease of heart

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Anderson M. D.

10/29 1930 (Address) 1714 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 11/2 1930

20 UNDERTAKER W. Cook

ADDRESS 1217 E. Fort Ave

Spec.—1-30—M. & T.—250 Bks.

E 61852

E 61852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH Bon Secours or City Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7-13 ST., WARD)

2-FULL NAME Margaret Fruthinger

(a) RESIDENCE NO. 941 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Elmer A Fruthinger

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Elizabeth New Jersey

PARENTS

10 NAME OF FATHER Leonard Lafetra ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ? Rupp ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Lafetra (Address) Baltimore City Hospitals

15 Filed ..... 19 .....

HAMPSON JONES, M. D. Registrar

0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29-30

17 I HEREBY CERTIFY, That I attended deceased from 9-17, 1930, to 10-29-1930, that I last saw h[illegible] alive on 10-29-, 1930, and that death occurred, on the date stated above, at 10-4 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Bilateral duketis gangrene

2 yrs.

(duration) 2 yrs. ~~for~~ ~~mos~~ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings.

(Signed) Fred M. Dunkelberg, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 10/31/30

20 UNDERTAKER Walthom Cook

ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61853

E 61853

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2330 N. Calvert St. (Ward) 12-50

2-FULL NAME Martha J. Stack

(a) RESIDENCE NO. 2330 N. Calvert St., 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-27-54

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country) Md

PARENTS

10 NAME OF FATHER James Stack

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah A. Potts

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. F. Heinzel
(Address) 2330 N. Calvert St

15 Filed 10 30 1930 J. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Hypertrophy Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

10/30, 1930 (Address) 2632 Woodland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Oct 31 1930

20 UNDERTAKER M E Gwynn

ADDRESS 841 W 37th

Important. See instructions on back of certificate.

30 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 61854

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ E 61854

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3925 Norfolk ave ST. 15-65 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Annie M Binnix

(a) RESIDENCE NO. 3925 Norfolk Ave ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced: HUSBAND of (or) WIFE of Frank Binnix

7 DATE OF BIRTH (month, day, and year) March 20-1865

AGE: 65 Years | Months 7 | Days 9 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House keeping

(b) General nature of industry, business, or establishment in which employed (or employer): Home Duties

(c) Name of employer: Self

BIRTHPLACE (city or town) (State or country): Harrisburg Pa.

10 NAME OF FATHER: Gustave Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Switzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frank Binnix

(Address): 3925 Norfolk ave

Filed: OCT 30 1930 Registrar: C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 E/930

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 1930, to Oct 29 1930, that I last saw her alive on Oct 29 1930, and that death occurred, on the date stated above, at 9.35 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs 10 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + Clinical Evn

(Signed) C. H. Jones, M. D.

10-31-1930 (Address) 4936 Parkside ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harrisburg Pa — DATE OF BURIAL: 10/31/1930

20 UNDERTAKER: Jno Cook — ADDRESS: 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61855

CERTIFICATE OF DEATH

188-002

E 61855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital St. 27-5 Ward)

2-FULL NAME Frank L. A Kreh.

(a) RESIDENCE NO. 4811 Gradon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Kreh

6 DATE OF BIRTH (month, day, and year) July 24, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Mfr
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER John L. Kreh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Krauss

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Lieutenant B Kreh
(Address) 4811 Gradon

19 [illegible] Registrar.

OCT 30 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident. Struck by Street Car at Park Lights Ave & Virginia Ave. Fractured Skull (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brownley M. D.

Oct 30 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md	10/31/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

E 61856 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 61856

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH 22 N. Ann Street 6-4
CITY OF BALTIMORE, MD. 22 N. Ann St. ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Curtis

(a) RESIDENCE NO. 22 N. Ann St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Curtis

6 DATE OF BIRTH (month, day, and year) April 8, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Randall Jackson
11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.
12 MAIDEN NAME OF MOTHER Mary Jackson
13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant E. J. Curtis
(Address) 22 N. Ann Street

Filed OCT 1 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 29 Oct. 30

17 I HEREBY CERTIFY, That I attended deceased from 29/7/30, to 29/10/30.
that I last saw h[illegible] alive on 28/10/30
and that death occurred, on the date stated above, at 1-30 p. m.

The CAUSE OF DEATH* was as follows:
Nephritis
over 3
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto, Md.
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Urinalysis
(Signed) L. Mayfield Bell M. D.
29/10/30 (Address) 1114 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery
DATE OF BURIAL Oct. 31st 1930
20 UNDERTAKER Theodore C. LaRue
ADDRESS 1131 E. Fayette St.

1-30—M. & T.—100 B—50L

61857

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 V E 61857

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital ST. 2-4 WARD)

2-FULL NAME Mary O'Neil

(a) RESIDENCE NO. 131 S Broadway ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? 61 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael O'Neill

6 DATE OF BIRTH (month, day, and year) Sept 13 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Meany

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Brennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine O'Neill

(Address) 131 S Broadway

15 Filed 3 1 1930 C. HILTON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Exhaustion yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of — —

Was there an autopsy? No

What test confirmed diagnosis? Ely Ex

(Signed) A C Strader, Coroner, M. D.

19 (Address) 1436 Fairway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 10 31 1930

20 UNDERTAKER Frank V. Pipstone

ADDRESS 2818 E Baltimore

Spec.—1-30—M. & T.—250 Bks.

E 61858 HEALTH DEPARTMENT—CITY OF BALTIMORE 13 E 61858

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard G. Tellingham

(a) RESIDENCE NO. 228 S. East St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3 1/2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Tellingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. Busse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

Filed 31 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1930, to Oct. 29, 1930, that I last saw him alive on Oct. 29, 1930, and that death occurred, on the date stated above, at 1 & 2 p m.

The CAUSE OF DEATH* was as follows:

Diarrhoea & enteritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cellulitis of neck

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Goodwin M. D.

10/29 1930 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Nov 1st 1930

ADDRESS 403 S. Wolfe St

20 UNDERTAKER Lilly & Gilbert Inc

Spec.—8-16-29—L. F. S.—100 Bks.

E 61859

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 E 61859

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Lafayette Ave ST. 14-23 WARD)

2—FULL NAME Mary Hunt

(a) RESIDENCE NO. 702 W Lafayette Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Edw Hunt

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

10 NAME OF FATHER: Jesse Hancock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Hancock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Edw Hunt

(Address) 702 Lafayette Ave

15 Filed 8 1 1930 C. HARRISON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29-30

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to Oct 29, 1930, that I last saw h[illegible] alive on Oct 29, 1930 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

(a) Acute Nephritis

(b) .....

(c) .....

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) C

(duration) C yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) John O Stewart M. D.

Oct 31 1930 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible]

DATE OF BURIAL: Nov 2 1930

20 UNDERTAKER: [illegible]

ADDRESS: [illegible]

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61860

CERTIFICATE OF DEATH.

90 E 61860

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 18-24 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Joseph Steffy

(a) RESIDENCE NO. 17 S. Schroeder ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Annie

6 DATE OF BIRTH (month, day, and year): Jan. 24, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): O'Y

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Massey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Records of Balto. City Hosp.

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-28-30

17 I HEREBY CERTIFY, That I attended deceased from 10-8-30, 19.. to 10-28-30, 19.., that I last saw h.. im alive on 10-28-30, 19.., and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic;
Arteriosclerotic

(Duration) UNKNOWN yrs. mos ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 1 Hour 2 Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Podgat, M. D.

10-30 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: 10/31/1930.

20 UNDERTAKER: John J. Cowan & Son.

ADDRESS: 901 Hollins

Cor.—12-9-25—A Co.—200 Bks.

E 61861

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

179 E 61861

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1431 Edmondson Ave. St. 19-27 Ward)

2-FULL NAME William P. Peters

(a) RESIDENCE NO. 1431 Edmondson Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Peters

6 DATE OF BIRTH (month, day, and year) August 12 1845

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	85	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Centreville

(State or country) Maryland

10 NAME OF FATHER Anderton Peters

11 BIRTHPLACE OF FATHER (city or town) London

(State or country) England

12 MAIDEN NAME OF MOTHER ? Palmer

13 BIRTHPLACE OF MOTHER (city or town) Centreville

(State or country) Maryland

14 Informant Mr. W. Stanley Peters

(Address) 1431 Edmondson Ave.

Filed [illegible] 1930 C. HAMILTON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

2nd & 3rd degree burns

Caught fire while smoking

Suicide (duration) yrs. Sudden

CONTRIBUTORY (Secondary) (duration) yrs.

(Signed) F. E. Lentz M. D.

Coroner

Oct 30 (Address) North ave & Division St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: Nov. 1 1930

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 61862 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61862

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 822 Edmondson Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Hattie Woods

(a) RESIDENCE NO. 822 Edmondson Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: James Woods

7 DATE OF BIRTH (month, day, and year): Dec 29-1890

AGE — Years: 39 | Months: 9 | Days: 29 | If LESS than 1 day, hrs. or min.:

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Anne Arundel Co Md

10 NAME OF FATHER: Thos. Polson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER: Jane Makel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co Md

Informant: James Woods

(Address): 822 Edmondson Ave

Filed OCT 31 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 28-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1930 to Oct 28, 1930

that I last saw h er alive on Oct 28, 1930

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart 30 Mins
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Bronchio Pneumonia
(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/27/30

Was there an autopsy? Post Mortem by Attend.

What test confirmed diagnosis?

(Signed) Jas E Bell, M. D.

, 19 (Address) 713 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Oct 31 1930

20 UNDERTAKER: Samuel Wamsley

ADDRESS: McCulloh

1-30—M. & T.—100 B—50L

E 61863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 166 ✓

E 61863

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

2-FULL NAME Evelyn Knight

(a) RESIDENCE NO Ferndale, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25-1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Robert Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robert Knight

(Address) Ferndale Md.

15 Filed 10/31/1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride of mercury poisoning. Suicide

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Ferndale, Md

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D. Coroner.

10/31 1930 (Address) 2739 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Nov. 1 1930

20 UNDERTAKER John J Fahey Sons — ADDRESS 1319 Light St

Spec.—1-30—M. & T.—250 Bks.

61864

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61864

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospital

CITY OF BALTIMORE: (NO. ..... ST., 17-24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Clark

(a) RESIDENCE NO. 526 N. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Moses Clark

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56 ?		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Norfolk
(State or country) Va.

PARENTS

10 NAME OF FATHER Daniel Pugh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Friends
(Address) Baltimore City Hosp.

15 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28-30

17 I HEREBY CERTIFY, That I attended deceased from 10-22-, 1930, to 10-28-, 1930, that I last saw her alive on 10-28-, 1930, and that death occurred, on the date stated above, at 8 3/4 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri with involvement

(duration) unknown

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) Fred W. Ouckwall, M. D.

, 19 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 10-31 19 30

20 UNDERTAKER David Corbin

ADDRESS 716 Dr no.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61865 (1)

E 61865 (2)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Providence Hospital St., Ward)

2-FULL NAME Hattie Chamberlain

(a) RESIDENCE NO. 537 Wilson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willie Chamberlain

6 DATE OF BIRTH (month, day, and year) Oct 8 - 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45		20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Carter Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rosa Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Willie Chamberlain (Address) 537 Wilson St

15 [illegible]

C 119306 HAMPSON JONES, M. F. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck & knocked down by motor auto

(a)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Provident

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Skull & Fem

(Signed) H. Hamm, M. D.

Oct 31 1930 (Address) 2934 E Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Oct 31 1930
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Presstman St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61866

CERTIFICATE OF DEATH.

129 E 61866

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1332 Carey ST. 15-23 (WARD)

2-FULL NAME Howard Yates

(a) RESIDENCE NO. 1332 Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, Oil

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charles Co Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) U

12 MAIDEN NAME OF MOTHER U

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U

14 Informant Rosa Campbell

(Address) 1332 n. Carey st.

15 Filed NOV 3 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/20 1930 to 10/26 1930, that I last saw him alive on 10/26 1930, and that death occurred, on the date stated above, at 2 30 m

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

Acute Dyspepsia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 434 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Nov 1 1930

20 UNDERTAKER Thomas E Kelson

ADDRESS 1303 Pennsylvania Ave

30—M. & T.—100 B—50L

61367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001

REGISTERED NO. E 61367

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp ST. 16-22 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Hall.

(a) RESIDENCE NO 1520 Riggs Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Elenor Hall

DATE OF BIRTH (month, day, and year) May 2 1877

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	5	23	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundry Engr
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

BIRTHPLACE (city or town) (State or country) West River Md

10 NAME OF FATHER Charles Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs Taylor

(Address) 1612 Penna Ave

Filed OCT 31 1930 . 192 . HANSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) & Autopsy find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) A. Louis Hirsh, M. D. Coroner

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Nov 1 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

Spec.—1-10-21—M&T—1500 Bks.

E 61868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

REGISTERED NO. E 61868

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital St., 7-9 WARD)

2-FULL NAME Morris Hymon

(a) RESIDENCE NO. 616 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White- Jewish

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE OF: Ida Hymon

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	48	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): clothing

(c) Name of employer: Stuart & Co.

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Benj. Hymon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Martin Hymon (Son)

(Address) 616 N. Washington St.

15 [illegible] 19 [illegible] JONES, M. D.

Registrar

31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-14 1930 to Death 19

that I last saw h[illegible] alive on 10-31- 1930,

and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas -

& Metastases -

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ascites - Inanition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hjalmar S. Anderson, M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Southern Ave

DATE OF BURIAL: 10-31- 1930

20 UNDERTAKER: Jack Isaac

ADDRESS: 1-3? [illegible]

Spec.—8-16-29—L. F. S.—100 Bks.

E 61869

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61869

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 Harlem Ave St., 17 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Mamie C. Payne

(a) RESIDENCE NO. 812 Harlem Ave St., 17 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon Payne

7 DATE OF BIRTH (month, day, and year) Oct 5, 1874

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	56		24	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Hughes Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Solomon Payne

(Address) 812 Harlem Ave

15 Filed ..... 19 (Registrar)

1930

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Oct 29, 1930, that I last saw her alive on Oct. 29, 1930 and that death occurred, on the date stated above, at 7.50 p m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart

Cardiac Failure

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Douglas Shepherd, M. D.

Oct 31 1930 (Address) 1063 Wyoming Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Nov 2, 1930

ADDRESS 3221 Edmondson Ave

20 UNDERTAKER Mrs Katie R. Williams

E. HAMPSON JONES

I-30—M. & T.—100 B—50L

E 61870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 61870

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 Otterbein ST. 21-29 WARD)

2-FULL NAME George Randall

(a) RESIDENCE NO. 216 Otterbein ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Randall

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laboner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo. Randall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nora Randall

(Address) 216 Otterbein

Filed OCT 31 1930 C. HAMPSON JONES, M. D. (Registrar)

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Feller, M. D. Coroner

10/30 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov 1, 1930
20 UNDERTAKER	ADDRESS 322
Mrs Katie R. Williams	Schroeder St

Spec.—1-30—M. & T.—250 Bks.

E 61871 E 61871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 701 Linwood Ave ST., 11 WARD)

2-FULL NAME Herman Block.

(a) RESIDENCE NO. 701 Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Emma [illegible]

6 DATE OF BIRTH (month, day, and year) 5/3/1862

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	68	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant Owner

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Leopold Block

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Mrs. Herman Block

(Address) 701 N Linwood Ave

15 Filed 31 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 30 to Oct 30 30

that I last saw alive on Oct 30 30

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Cardiac-Dropsy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct 31 1930 Address 801 N Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forestwood Cem.

DATE OF BURIAL 11/1/30.

20 UNDERTAKER George J. Pettit Inc

ADDRESS 1735 Harford

HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 61872

E 61872

HEALTH DEPARTMENT—CITY OF BALTIMORE 33

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Lh Jones Hospital REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6 Caroline St., 22 WARD)

2-FULL NAME Nancy Collier

(a) RESIDENCE NO. 657 W Baltimore ST., ... WARD 22
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Collier

6 DATE OF BIRTH (month, day, and year) .....

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. H. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Caroline

12 MAIDEN NAME OF MOTHER Grace Conner Gary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Wm. H. Stewart
(Address) 763 S. Charles St.

15 Filed 10/31 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28-1930

17 I HEREBY CERTIFY, That I attended deceased from 10-6-30, 19..... to 10-28-30, 19....., that I last saw h[illegible] alive on 10-28-30, 19....., and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:
Intramural Peritonitis
Intramural Appendicitis
2B Lymphosarcoma Mesent
(duration) ..... yrs. mos 22 ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) ..... yrs. ..... mos.) ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/27/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) Lh Jones Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemty

DATE OF BURIAL 10/31 19 30

20 UNDERTAKER Walter B. Driggs

ADDRESS 1399 W Hamburg St.

Spec.—1-10-21—M&T—1500 Bks.

Roweua V LeCompte.

E 61873

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61873

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 714 N Carlington Ave (Hospital, Asylum, etc.) (WARD) 23

2-FULL NAME Roweua Virginia LeCompte

(a) RESIDENCE No. 714 N Carlington Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. X mos. X ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stephen LeCompte

6 DATE OF BIRTH (month, day, and year): June 18, 1846

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
84	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fredelsburg Dorchester Co. Md.

PARENTS

10 NAME OF FATHER: John Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredelsburg Dorchester Co Md

12 MAIDEN NAME OF MOTHER: Annie Dines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fredelsburg Dorchester Co Md

14 Informant: Stuart B LeCompte

(Address): 714 N Carlington Ave

15 Filed: T 31 1930

C. HANDY JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1930, to Oct 30th, 1930, that I last saw h alive on Oct 30th, 1930, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) X yrs. 6 mos X ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Tumor in Stomach

(Signed) W Wm Williams, M. D.

, 19 (Address) 2200 Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 1 1930

UNDERTAKER: George J Smith — ADDRESS: 153 L Hollins

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61874

E 61874

CERTIFICATE OF DEATH

REGISTERED NO. 101-00

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 919 Denver St. St., 01-29 Ward)

2-FULL NAME Robert E. Gross. (C)

(a) RESIDENCE NO. 919 Denver St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) September 5, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	4	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Roland Gross. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Marie Blue. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Marie Gross. (C) mother.
(Address) 919 Denver St.

15 Filed 10 31 1930 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto W. Reinhardt, M. D.

10/29. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Nov 1930
20 UNDERTAKER	ADDRESS
Joseph Selvey	419 N Monr

Spec—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61875

CERTIFICATE OF DEATH.

38 E 61875

1-PLACE OF DEATH Bacto City Hospls

CITY OF BALTIMORE: (No. Balto Md. ST. 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Sundstrom,

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) Sailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records Bacto City Hospls
(Address)

15 Filed 31 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/29/30

17

I HEREBY CERTIFY, That I attended deceased from 9-18-, 1930, to 10/29/, 1930,

that I last saw him alive on 10/29/, 1930,

and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Gen. Path. Serological

(Signed) Wm. H. Adams M. D.

10/29 1930 (Address) Balto. City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem

DATE OF BURIAL Oct. 31 1930

20 UNDERTAKER Stephen J. Fallowski Inc

ADDRESS 1000 d Kenwood Ave

Per JOHN M. [illegible] Registrar

Spec.—9-30—A. & Co.—250 Bks.

E 61876 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 61876

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE. (No. 3540 Roland Av ST. 13-57 WARD)

2 FULL NAME Georgia Marie Hare

(a) RESIDENCE NO. 3540 Roland Av ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clarence A Hare

6 DATE OF BIRTH (month, day, and year) Aug 27 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) MD
(State or country)

PARENTS

10 NAME OF FATHER Jacob Keller

11 BIRTHPLACE OF FATHER (city or town) MD
(State or country)

12 MAIDEN NAME OF MOTHER Dora Wagner

13 BIRTHPLACE OF MOTHER (city or town) MD
(State or country)

14 Informant Clarence A Hare
(Address) 3540 Roland Ave

Filed 31 1930 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29/30

17

I HEREBY CERTIFY, That I attended deceased from July 1st, 1930, to Oct 30th, 1930

that I last saw h[illegible] alive on Oct 29th, 1930

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Lung pre-
ceded by sarcoma of back
which was removed Jan 22/30.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 22/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Oct 30, 1930 (Address) 8-6 W 39th St Balto

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Lodge

DATE OF BURIAL Nov 1 1930

20 UNDERTAKER Chenowith Bros

ADDRESS 2615 Eutaw

Medle

HEALTH DEPARTMENT—CITY OF BALTIMORE

61877 61877

CERTIFICATE OF DEATH.

REGISTERED NO. C 185

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1827 Ex St. Agnes Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Addie Mendell (Medle)

(Residence in Baltimore: No. 1827 Dover St.; yrs. 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Aug. 12, 1860 (Month) (Day) (Year)

7-AGE, 70 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Coyne

(Address) 1827 Dover Street

15-

Filed C. HAMPSON JONES, M. D. Registrar.

NOV 1 1930

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30, 1930 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis Fell down on floor at home Fracture of skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. H. Brack M. D. (Coroner)

Oct 31 1930 (Address) Broadway Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State. ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL London Park Cemetery DATE OF BURIAL, Nov. 1, 1930

20-UNDERTAKER George L. Schwabrow ADDRESS Fred. Md.

Spec.—8-16-29—L. F. S.—100 Bks.

E 61878

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61878

CERTIFICATE OF DEATH

REGISTERED NO. 91-30 E 61878

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St.Paul Aparts. ST. 11-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary D. Dungan

(a) RESIDENCE NO. St.Paul Aparts. ST., Mt.Royal & St.Paul WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. 6 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. W. Dungan

6 DATE OF BIRTH (month, day, and year) May 27 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Thorndike Chase

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER b Clementine G.Darelle

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country) Balto.

14 Informant Lillian C.Michael

(Address) St.Paul Aparts.

15 Filed 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Oct 29, 1930, that I last saw her alive on Oct. 29, 1930 and that death occurred, on the date stated above, at 11-9 a.m.

The CAUSE OF DEATH* was as follows:

Uremia Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oesthenia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B Gamble, M. D.

19 (Address) 26 N. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Nov1.1930 19

20 UNDERTAKER John O.Mitchell & Sons John O. Mitchell and Sons

ADDRESS 1900 Eutaw Pla

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61879

CERTIFICATE OF DEATH.

154-E 61879

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1201 W 41 ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mc Gurry

(a) RESIDENCE NO. 1201 W 41 ST., 13 WARD 6

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/31/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	0	0	1 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balt md

PARENTS

10 NAME OF FATHER Edward Mc Gurry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt md

12 MAIDEN NAME OF MOTHER Mary Mc Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Edward Mc Gurry
(Address)

15 1930 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/31, 1930, to 10/31, 1930, that I last saw h— alive on 10/31, 1930, and that death occurred, on the date stated above, at 6.30 H. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1/4 ds.

CONTRIBUTORY (Secondary) Diphtheria

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis? Clinical

(Signed) C. F. Cleary M. D.

Nov. 1, 1930 (Address) 1201 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11/3/1930

20 UNDERTAKER Geo J Roth Inc Undertakers

ADDRESS 1138 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61880

E 61880

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 27-56 WARD)

2-FULL NAME Mrs Nellie Scheafer

(a) RESIDENCE NO. 3311 St Ambrose Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Angelo J Scheafer

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 63 Months Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Angelo Mufkowa

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Nellie J. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Leo Scheafer

(Address) 3311 St Ambrose Ave

1 1930

15 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-5 1930 to 10-29 1930.

that I last saw her alive on 10-29 1930.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt Lewis, M. D.

(Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL 11/1 1930

ADDRESS 1136

20 UNDERTAKER H C Brumm & Son Poplar grove

Spec.—2-29-28—L. F. S.—500 Bks.

E 61881

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61881

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leshen M. Timmons

(a) RESIDENCE NO. Magnolia ST. Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 15, 1895

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	2	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Magnolia, Md.

10 NAME OF FATHER John E. Timmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Litchfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hospital Records

(Address)

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

1 1930 Pat Rich

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1930, to Oct. 31, 1930

that I last saw h~~im~~ alive on Oct. 31, 1930

and that death occurred, on the date stated above, at 1:55 P. m.

The CAUSE OF DEATH* was as follows:

Septic Infection Throat,
(Septic sore throat)

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Magnolia, Md.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical Findings.

(Signed) Robert V. Leonetti, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Christian Cemetery

DATE OF BURIAL Nov 3 1930

20 UNDERTAKER Howard K. McComas

ADDRESS Abingdon Md

Spec.—1-30—M. & T.—250 Bks

E 61882 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61882

CERTIFICATE OF DEATH.

REGISTERED NO. ____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) University Hospital ST. 18-26 WARD)

2-FULL NAME Annie Elizabeth Schmidt

(a) RESIDENCE NO. 839 W Saratoga ST., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, ~~Married, Widowed, or Divorced, (write the word)~~:

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7- 1928

7 AGE — Years: 2 | Months: 9 | Days: 24 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Geo A Schmidt
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore
12 MAIDEN NAME OF MOTHER: Pauline Carroll
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: George A Schmidt
(Address): 839 W Saratoga St

Filed Oct 31 1930 19 Mar C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Oct 31, 1930, that I last saw her alive on Oct 30, 1930, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia, Malnutrition
Rickets

(duration) 3 yrs. ____ mos ____ ds.

CONTRIBUTORY (Secondary) Secondary anemia
(duration) Unknown yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical data

(Signed) William H Varney M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem
DATE OF BURIAL: Nov 3 1930
20 UNDERTAKER: Robert Brookerson
ADDRESS: Calhoun Hollins

61883

1 PLACE OF DEATH
County City Baltimore

100-001 ✓ E 61883

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. .....

Village or City Balto (No. 2030 Maisel St. Ward) 25 - 12

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Harry Keyser

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH May 13 (Month) (Day) 1930 (Year)

7 AGE yrs. 5 mos. 17 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Keyser
11 BIRTHPLACE OF FATHER (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Emma Miller
13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Keyser
(Address) 2030 Maisel st

15 1930 G. HAMPSON JONES, M. D.
Filed ..... 1931 Oct 6 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 30 (Month) (Day) 1930 (Year).

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930 to Oct 30, 1930 that I last saw h[illegible] alive on Oct 30, 1930 and that death occurred on the date stated above, at 12 m. midnight

The CAUSE OF DEATH * was as follows:

Malnutrition

(Duration) 2 yrs. 7 mos. ds.

Contributory Secondary Burden Pneumonia

(Duration) yrs. 3 mos. ds.

(Signed) G. Hampson Jones M. D.
Oct 31, 1930 (Address) 2030 Maisel Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Balto Cemetery — DATE OF BURIAL: 11/2/30

20 UNDERTAKER: Wm Cook — ADDRESS: 127 St Paul St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Spec.—1-30—M. & T.—250 Bks

E 61884

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61884

CERTIFICATE OF DEATH.

135

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 16-39 ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel J. Smith

(a) RESIDENCE NO. 3532 Noble ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Florence

6 DATE OF BIRTH (month, day, and year) Mar. 30, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman; Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer) 650

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sussex Co. Delewere

PARENTS

10 NAME OF FATHER David

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant (Address) Records of Balto. City Hosp.

15 Filed 31 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-30

17 I HEREBY CERTIFY, That I attended deceased from 10-7-30, 19 ... to 10-30-30, 19 ...

that I last saw h im alive on 10-30-30, 19 ...

and that death occurred, on the date stated above, at 7:55 P m.

The CAUSE OF DEATH* was as follows:

Cystitis and Pyelitis new

(duration) yrs. 10 mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerotic heart disease (duration) unknown yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of autopsy

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Puget, M. D.

10-31, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 11/3 1930

20 UNDERTAKER Wilburn Cook

ADDRESS 1219 E Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61885

REGISTERED NO. E 61885

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 510 Chapel Gate) ST. (OR WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad Knabe

(a) RESIDENCE NO. 510 Chapel Gate WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Knabe

7 DATE OF BIRTH (month, day, and year) Apr 13, 1867

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	6	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Retired

(b) General nature of industry, business, or establishment in which employed (or employer) self

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Charles Knabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Schmaltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Kate E. Knabe

(Address) Chapel Gate Lane

Filed 31 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-30

17 I HEREBY CERTIFY, That I attended deceased from 12-29-30 to 10-30-30, 19 30

that I last saw him alive on 10-29, 19 30 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis 5

CONTRIBUTORY (Secondary) Exhaustion (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

10/31/30 (Signed) Byron M. Emory, M. D.

(Address) 400 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 11/1 19 30

20 UNDERTAKER J. H. Mark

ADDRESS 1217 Eutaw St

Spec.—1-30—M. & T.—250 Bks.

E 61886

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90 E 61886

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1323 Homestead ST. 9-4 WARD)

2-FULL NAME Annie M Pryor

(a) RESIDENCE No. 1323 Homestead ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of James E Pryor

6 DATE OF BIRTH (month, day, and year) Jan 14, 1855

7 AGE Years 75 Months 4 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Virginia A Hensley

(Address) 3013 Madrid Ave

15 Filed 10/31 1930 19 H. MASON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from October 4, 1930, to Oct. 29, 1930, that I last saw her alive on Oct 29, 1930, and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis —

(duration) 4 yrs. — mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) A. F. Robinson M. D.

10/31, 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 11/1 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Fond St

Spec.—9-30—A. & Co.—250 Blks

E 61887 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61887

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE, (No.) 3101 Batavia Ave (St.) WARD 27-44

2 FULL NAME Dr. William B. Larmour

(a) RESIDENCE No. 3101 Batavia Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace B. Larmour

6 DATE OF BIRTH (month, day, and year) Dec 14, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm B. Larmour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Virginia Moffet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Grace B Larmour 3101 Batavia Ave

15 Filed 1 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 27th, 1930 to Oct 28th, 1930 that I last saw him alive on Oct 28th, 1930 and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 (a) BURIAL, CREMATION OR REMOVAL Baltimore

20 UNDERTAKER William Cook

DATE OF BURIAL Nov 1 1930

ADDRESS 1217 E Baltimore St

8spec.—1-30—M. & T.—250 Bks.

E 61888

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61888

CERTIFICATE OF DEATH.

+ 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. St. 1244 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Champlin Robinson

(a) RESIDENCE NO. Lutherville, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 1-3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced (HUSBAND of or) WIFE of (Hettie CLARK) Mrs Champlin Robinson

6 DATE OF BIRTH (month, day, and year) Aug 28 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oil dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

10 NAME OF FATHER Mr. E. A. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Newport R.I.

12 MAIDEN NAME OF MOTHER Alice Canby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

PARENTS

14 Informant Mrs H. Champlin Robinson (Address) Lutherville Md.

15 [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19th, 1930, to Oct 31st, 1930.

that I last saw him alive on Oct 31st, 1930,

and that death occurred, on the date stated above, at 11.10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic arteriosclerotic heart disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests

(Signed) Richard Hance, M. D.

19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL Nov 3rd 1930

20 UNDERTAKER Henry H. Trenchard & Co

ADDRESS McCulloh & Eutaw St

-1930

1-30—M. & T.—100 B—50L

E 61889

HEALTH DEPARTMENT—CITY OF BALTIMORE

VE 61889

CERTIFICATE OF DEATH

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1332 N. Stricker St. (WARD) 15-22

2-FULL NAME Theresa Clayton

(a) RESIDENCE No. 1332 N. Stricker St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of NO

6 DATE OF BIRTH (month, day, and year) 8-29-1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Harrison Clayton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Virginia Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Virginia Clayton

(Address) 1332 N. Stricker St.

15 Filed ..... 192 HAMILTON JONES, M. D. Registrar

- 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Autopsy thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. Hamilton Jones, M. D. Coroner

Oct 30 1930 (Address) Govans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kensale Hist Moreland Co. Md

DATE OF BURIAL Nov 1st 1930

20 UNDERTAKER A. Jones

ADDRESS 411 S. Gilmor

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61890 101-001 E 61890

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1934 Laurella St. (Ward) 30-27

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Donald Johnson

(a) RESIDENCE NO. 1934 Laurella St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mal

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Singe

6a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept 3rd 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Amos Johnson

11 BIRTHPLACE OF FATHER (city or town) Hampton
(State or country) Va

12 MAIDEN NAME OF MOTHER Rosie Hammond

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Amos Johnson

(Address) 1934 Laurella St.

15 Filed 1930 G. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. Hunt Keech, M. D. Coroner

(Address) Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary

DATE OF BURIAL Sept 30 1930

20 UNDERTAKER Virginia A. Brooks

ADDRESS 1463 N. Carey St

Spec.—8-16-29—L. F. S.—100 Bks.

E 61891

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61891

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 E. Fayette ST. 6-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Kuhn

(a) RESIDENCE NO. 2020 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) June 30/1859

AGE: Years 71 | Months 4 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

10 NAME OF FATHER: Valentine Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switz.

12 MAIDEN NAME OF MOTHER: Elizabeth Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger

14 Informant: Mrs. Mary Kuhn

(Address) 2020 E. Fayette

15 Filed: ..... C. HAMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1930, to Oct 31, 1930, that I last saw h[illegible] alive on Oct 31, 1930 and that death occurred, on the date stated above, at 8.45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

?

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel B. Wolfe, M. D.

10/31, 1930 (Address) 1331 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Nov. 3 1930

20 UNDERTAKER: Jos. J. Birr

ADDRESS: 1564 N. Luzerne

Spec.—8-16-29—L. F. S.—100 Bks.

E 61892

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61892

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 W. Lanvale St. ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline L. Lautenbach,

(a) RESIDENCE NO. 2410 W. Lanvale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

6 If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Ferdinand Lautenbach,

7 DATE OF BIRTH (month, day, and year) February 15. 1850

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER George Meyer,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Lippold,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dr Ferdinand Lautenbach (Address) 2916 Guilford Ave

15 Filed NOV -1930 G. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 31 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to Oct 31, 1930, that I last saw h~~er~~ alive on Oct 31, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis acute

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N/ Date of m

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo W Kemmler, M. D.

Nov. 1930 (Address) 300 E Barnum Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park

DATE OF BURIAL NOV 3 - 1930

20 UNDERTAKER E. Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—1-30—M. & T.—250 Bks

E 61893 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61893

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3111 Walbrook Ave. ST. 15-67 (WARD)

2-FULL NAME Florence E. Hampton

(a) RESIDENCE NO. 3111 Walbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced (HUSBAND of or) WIFE of Herbert E. Hampton

6 DATE OF BIRTH (month, day, and year) June 8-1873

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Leonard Long

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Adeline Stahl

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Herbert E. Hampton

(Address) 3111 Walbrook Ave

15 1930 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1930, to Oct 30, 1930, that I last saw HER alive on Oct 30, 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH was as follows:

Left Lobar Pneumonia

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos 1 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical findings

What test confirmed diagnosis?

(Signed) J. N. Wilson M. D.

Oct 31, 1930 (Address) 848 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Nov 3 1930

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. North Ave

Spec.—1-30—M. & T.—250 Bks

E 61894

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61894

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3801 Jumpers Road ST. 12-49 WARD

2-FULL NAME Roosevelt Field

(a) RESIDENCE NO. 3801 Jumpers Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Isaac Field

6 DATE OF BIRTH (month, day, and year): May 1869

7 AGE — Years: 61 — Months: 7 — Days: 19 (21) — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Farm

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Theodore Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Rosanna Riddle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Isaac Field (Address) 3801 Jumpers Road

15 Filed 1-1930, 19 — THOMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/30/30

17 I HEREBY CERTIFY, That I attended deceased from 9/27, 1930, to 10/29, 1930, that I last saw h[e] alive on 10/29, 1930, and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
& pulmonary oedema

(duration) ....yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Angina (duration) ....yrs. ....mos. ....ds. — frequent attacks of Angina during past year

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Chas. Hebbard M. D.

1930 (Address) 1402 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Nov. 1, 1930

20 UNDERTAKER: Wm. J. Tuckner

ADDRESS: Lex Mark & Pa Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61895

CERTIFICATE OF DEATH

LAR 29 ✓

REGISTERED NO. E 61895

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N Fulton ST. W-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank R Lane

(a) RESIDENCE NO. 414 N Fulton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Lizzie L Lane

DATE OF BIRTH (month, day, and year) Jan 30, 1862

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	9		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Ed Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Horine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs Lizzie L Lane

(Address) 414 N Fulton

Filed ..., 19... E. HAMPTON JONES, M. D.
Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30-1928

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1928, to Oct 30, 1928,

that I last saw h alive on Oct 30, 1928

and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) 15 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John L Lane M. D.

1928 (Address) 612 N 40 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Nov. 1 19 28
UNDERTAKER Wm. J. Tickner & Sons	ADDRESS N Paca

30—M. & T.—100 B—50L

E 61896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

187-00 E 61896

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp ST., 18-6 WARD)

2-FULL NAME John Lloyd.

(a) RESIDENCE NO 904 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced HUSBAND (or) WIFE of: Mary Lloyd

6 DATE OF BIRTH (month, day, and year): Sept 13 1876

7 AGE: Years 34 | Months 1 | Days 17 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Sparrow Point
(c) Name of employer: L Co.

9 BIRTHPLACE (city or town) (State or country): L Co.

10 NAME OF FATHER: Frank Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): L Co.

12 MAIDEN NAME OF MOTHER: Mary Darby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): L Co.

14 Informant: Mary Lloyd

(Address): 904 W Fayette

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above. The CAUSE OF DEATH* was as follows: Accidental Injured by Laundryman from belt Gas Gangrene

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Fractured Femur.

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? Sparrow Point

Did an operation precede death? yes Date of Oct 29

Was there an autopsy? No

What test confirmed diagnosis? Regulay

(Signed) ..... M. D. Coroner

(Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Camden L.Co.

DATE OF BURIAL: 11-2nd 1930

20 UNDERTAKER: Chas. Jos Skinner

ADDRESS: 1625 E Fred St

Spec.—1-30—M. & T.—250 Bks.

E 61897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61897

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1114 Mosher St. (WARD) 16-32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Diggetts

(a) RESIDENCE NO. 1114 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary Diggetts

6 DATE OF BIRTH (month, day, and year) March 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Standard Fertilizer Co

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Reuben Diggetts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Diggetts

(Address) 1114 Mosher

15 Filed 1930 . 19 JOHN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 8 , 1930 , to Oct 31 , 1930 ,

that I last saw h[illegible] alive on Oct 30 , 1930

and that death occurred, on the date stated above, at 6.55 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis ++

Chronica (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Age - Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical - Lumbal

(Signed) Wm H Wright M. D.

Oct 31 , 1930 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 11-2 , 1930

20 UNDERTAKER Wm H Crane Son & Meyer

ADDRESS 14 & N Mad

Spec.—2-29-28—L. F. S.—500 Bks.

E 61898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/v E 61898

1—PLACE OF DEATH

REGISTERED NO. 12-54

CITY OF BALTIMORE: (No. 2227 Madison ave STREET WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Stovall

(a) RESIDENCE NO. 2227 Madison ave STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 3 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	

If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

DATE OF BIRTH (month, day, and year): July 21 1908

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	3	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Morris P Stovall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sylvia Ware

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

Informant: Sylvia Stovall

(Address) 2227 Madison Ave.

Filed 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30-30

17

I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1930 to Oct. 30, 1930

that I last saw h[illegible] alive on Oct 30, 1930

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

auto-Toxemia

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. 6 mos. 7 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins, M. D.

10-30, 1930 (Address) 1012 N. Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov 2 1930
20 UNDERTAKER	ADDRESS
James H. Chase Inc	1430 Madison

Spec.—1-12-23—M&T—500 Blks.

E 61899

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61899

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 2509 Sidney Ave (ST.) Westport (WARD) 25-32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn S (Miller)

(a) RESIDENCE NO. 2509 Sidney ST. Westport WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6-1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	22	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Chas H Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Roy Bamon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Chas. Henry Miller Jr. (Address) 2509 Sidney Ave

15 Filed [illegible] 19 [illegible] 1930

[illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1 1930 to Oct. 30 1930.

that I last saw HER alive on Oct. 30 1930

and that death occurred, on the date stated above, at 11:00 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Indefinite

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. L. Campbell, M. D.

10/31 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL Nov 1 1930

20 UNDERTAKER Daniel Carter

ADDRESS 916 Eager

Spec.—1-30—M. & T.—250 Bks.

E 61900 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61900

38

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Booth ST., 18-24 WARD)

2-FULL NAME Viola Rice

(a) RESIDENCE NO. 1020 Booth ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced (HUSBAND) of or) WIFE of: Berkley Rice

6 DATE OF BIRTH (month, day, and year): 1 - 1890

7 AGE — Years: 40 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Raleigh N.C.

10 NAME OF FATHER: Rev. Abernathy

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Lentroom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant: Berkley Rice
(Address): 1020 Booth St.

15 Filed ..... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/30/30

17 I HEREBY CERTIFY, That I attended deceased from 10/20/30, 19 30, to 10/30/, 19 30,
that I last saw her alive on 10/29/, 19 30,
and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

Mitral (duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis - Cirrhosis Liver (duration) 1 yr (redacted)

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Burley M. D.

10/31/30 (Address) 608 Shar[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Nov 1 19 30

20 UNDERTAKER: Dent Funeral

ADDRESS: City

Spec.—3-30—M. & T.—250 Bks.

E 61901 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61901

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. St. Joseph's Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Holbrook

(a) RESIDENCE NO. 1127 Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1911

8 AGE: Years 19 | Months — | Days — | If LESS than 1 day, ...hrs. or ....min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

11 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Blanche

(Address)

15 Filed ... 19... JOHN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-30

17 I HEREBY CERTIFY, That I attended deceased from 10-20, 1930, to 10-30, 1930,

that I last saw her alive on 10-30-30, 19...,

and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? X-Ray

(Signed) Lawrence M. Sears, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Nov 1 1930

20 UNDERTAKER Frank Eastern

ADDRESS 974 Dallas.

Spec—1-30—M. & T.—250 Blks

E 61902 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61902

CERTIFICATE OF DEATH.

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4105 Chesley Ave ST., Greenlee WARD)

2-FULL NAME M. Clifford McCausland

(a) RESIDENCE NO. 4105 Chesley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced: (HUSBAND of or) WIFE of: Emma G. McCausland

6 DATE OF BIRTH (month, day, and year): June 30th 1900

7 AGE: Years 30 Months 4 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Auto mechanic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Schmidt Bakery

9 BIRTHPLACE (city or town) (State or country): Harford Co. Maryland

PARENTS

10 NAME OF FATHER: Marcus H McCausland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Maryland

12 MAIDEN NAME OF MOTHER: Mary J. Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co. Maryland

14 Informant: Emma G. McCausland

(Address) 4105 Chesley Ave.

15 Filed 1930 H. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Oct 31, 1930, that I last saw him alive on Oct 31, 1930, and that death occurred, on the date stated above, at 2.20 A.M.

The CAUSE OF DEATH* was as follows:

Acute bacterial endocarditis

(duration) yrs. 2 1/2 mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Alex Brechet, M. D.

10/31/1930 (Address) Maydean & Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Nov. 3 1930

20 UNDERTAKER: Frederick Lauraine Sons — ADDRESS: 901 Belair Rd

Spec.—1-30—M. & T.—250 Bks.

E 61903

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61903

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lunar Hospital ST., 27-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William De Vaughn

(a) RESIDENCE No. 4008 Chesley Ave. Overlea ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of, or) WIFE of: Mary C. DeVaughn

7 DATE OF BIRTH (month, day, and year): Nov 11th 1877

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tool Grinder

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer: Bethlehem Steel Co.

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

10 NAME OF FATHER: William DeVaughn

11 BIRTHPLACE OF FATHER (city or town): Alexandria

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Ahern

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Mary DeVaughn

(Address) 4008 Chesley Ave Overlea

15 Filed 1-1930, 19 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1930, to Oct. 30, 1930,

that I last saw h) alive on Oct. 30, 1930,

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pentontes + Cardiac Failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Guerman, M. D.

, 19 (Address) Lunar Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Nov. 3 1930
20 UNDERTAKER	ADDRESS
Frederick Lanahan	7401 Belair Rd

Spec.—1-30—M. & T.—250 Blks.

E 61904 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61904

CERTIFICATE OF DEATH.

REGISTERED NO. 8-17 100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irvin Miller

(a) RESIDENCE NO. 1613 ~~Fairbourn~~ Place Earleckson Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) January 13, 1930

8 AGE Years Months 9 Days 18 If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Oakland Md.

11 NAME OF FATHER Joseph Miller

12 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

13 MAIDEN NAME OF MOTHER Julia Jirsa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

PARENTS

14 Informant Joseph Miller (Address) 1613 Earleckson Place

15 Filed 1-1930 19 C. HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1930, to Oct. 31, 1930, that I last saw h[illegible] alive on Oct. 31, 1930, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) [illegible], M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz's Cemetary

DATE OF BURIAL Nov. 1 1930

20 UNDERTAKER Frederick Lassahn

ADDRESS 7401 Belair Rd.

Spec.—B 20—A. & Co.—250 Rls.

E 61905 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61905

CERTIFICATE OF DEATH

REGISTERED No. ____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4402 Kavanagh Ave (or) 26-41 (WARD) 90

2. FULL NAME Hazel Elizabeth Porter

(a) RESIDENCE No. 4402 Kavanagh Ave ST. ____ WARD ____ (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE (Single, Married, Widowed, or Divorced, (write the word)) White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Porter

6 DATE OF BIRTH (month, day, and year) May 18 1885

7 AGE: Years 45 Months 5 Days 13 If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isiah Truman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alexander Porter (Address) 4402 Kavanagh Ave

15 Filed ____ 1930 19 ____

C. HAMPSON JONES, M. D. Per ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 24 19 30 to Oct 30 19 30 that I last saw her alive on Sept 29 19 30 and that death occurred, on the date stated above, at 10 A M

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) 3 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy?

What test confirmed diagnosis? Examination

(Signed) E. H. Grandella M. D.

19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL Nov 3 1930

20 UNDERTAKER J. M. Cook

ADDRESS 1217 Eutaw St

Spec.—12-8-25—A Co.—300 Bks.

E 61906

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61906

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 W Ostend St. 23-31 Ward)

2-FULL NAME Mrs Sallie Walter

(a) RESIDENCE NO. 19 W Ostend St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Amos Walter

6 DATE OF BIRTH (month, day, and year) 3 11 1864

7 AGE: Years 66 | Months 7 | Days 19 | IF LESS than 1 day.....hrs. or.....min. 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Orlean Va

PARENTS

10 NAME OF FATHER A J. Parr

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Orlean Va

12 MAIDEN NAME OF MOTHER Julia Moore

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country) Orlean

14 Informant Mrs Effie Fiery

(Address) 19 W Ostend St.

15 Filed 1-1930, 19 HARRISON JAMES H. Registrar

Per ART

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 1 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Nov 1, 1930, that I last saw h[illegible] alive on Oct 31, 1930, and that death occurred, on the date stated above, at 8.40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valv Heart Dis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Goiter

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. J. Burlington, M. D.

, 19 (Address) 2102 E. Holly St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Warrenton Va. Date of Burial 11/2 1930

20 UNDERTAKER: I. Few McCulley ADDRESS 130 E Front

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61907

E 61907

CERTIFICATE OF DEATH

REGISTERED NO. 24-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1141 Wilmer ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Woodward

(a) RESIDENCE NO. 1141 Wilmer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Singleton Woodward

7 DATE OF BIRTH (month, day, and year) 1868

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Geo. Kidout

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marion Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Daisy Woodward

(Address) 114 Wilmer St

Filed OCT 1 1930, 19 HAMPSON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Oct 29, 1930, that I last saw h[illegible] alive on Oct 29, 1930 and that death occurred, on the date stated above, at 8-A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis (duration) 5 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas. J. Kullen, M. D.

10/30, 1930 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hall Cem. DATE OF BURIAL Nov 2 1930

ADDRESS 578

20 UNDERTAKER Samuel Hensley & Bro

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61908

E 61908

CERTIFICATE OF DEATH.

REGISTERED NO. 74002

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 1423 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Chandler

(a) RESIDENCE NO. 706 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Levinia Chandler

6 DATE OF BIRTH (month, day, and year) Oct. 22, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Orange Co. Va.

10 NAME OF FATHER William Chandler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Willie Ann ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Records of Balto. City Hosp.

15 Filed 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-30

17 I HEREBY CERTIFY, That I attended deceased from 4-2-30, 19 , to 10-30-30, 19 ,

that I last saw him alive on 10-30-30, 19 ,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Thrombosis, cerebral,

Rt. middle cerebral artery.

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Hypertension and Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

10-31, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Pk

DATE OF BURIAL Nov 2, 1930

20 UNDERTAKER Samuel Newsley

ADDRESS 578 N. Eutaw

Spec.—1-30—M. & T.—250 Bks.

E 61909

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61909

151

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Druid Hill Ave STR. 11-30 WARD)

2-FULL NAME Mose Howard

(a) RESIDENCE NO. 2016 Druid Hill Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Susan Howard

6 DATE OF BIRTH (month, day, and year) — — 1875

7 AGE: Years 55; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horse [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Md

14 Informant: Elsie Evans

(Address) 2016 Druid Hill Ave

15 Filed Oct 31 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Oct 30, 1930, that I last saw h[illegible] alive on Oct 29, 1930, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

Tuberculosis Laryngeal

(duration) yrs. 2 mos 21 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Clinical

(Signed) [illegible] M. D.

10/31, 1930 (Address) 924 Gladison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Nov 2 1930

20 UNDERTAKER: Samuel Mundey & Sons

ADDRESS 518 [illegible]

Spec.—1-30—M. & T.—250 Bks

E 61910 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61910

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 11-24 ST. ..... WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garnet Fax

(a) RESIDENCE NO. 720 Linden Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lee Fox

7 DATE OF BIRTH (month, day, and year) Dec. 29, 1898

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
31	32	10	1	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

10 NAME OF FATHER Thomas Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Gussie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

Filed 1-1930, 19 C. HAMPSON JONES, M. D.
By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-30

17 I HEREBY CERTIFY, That I attended deceased from 10-18-30, 19..., to 10-30-30, 19...,
that I last saw her alive on 10-30-30, 19...,
and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic
and acute.
(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Hypertension unknown
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

Oct 30, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn.

DATE OF BURIAL Nov 1 19 30

20 UNDERTAKER Edmund Newsley

ADDRESS 578 Fulton Ave

Spec.—1-30—M. & T.—250 Bks.

E 61911

E 6891

241 8 8 9

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Mary Miller

(a) RESIDENCE NO. 219 N. Dunham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Child

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12 1925

7 AGE: Years 5 Months Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elsie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records

(Address)

15 Filed Nov. 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29-30

17 I HEREBY CERTIFY, That I attended deceased from 10/21, 1930, to 10/29, 1930, that I last saw her alive on 10/29/30, 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paratyphoid fever (B)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of no

Was there an autopsy? Yes.

What test confirmed diagnosis? Agglutination & paratyphoid

(Signed) J. Campbell Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon County

DATE OF BURIAL: Nov. 1 1930

20 UNDERTAKER: Mrs. R. G. Elbert

ADDRESS 1723 Ashland Ave

Spec.—1-30—M. & T.—250 Bks.

2 4 2 0 4 2
E 61912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156

E 61912

REGISTERED NO. 1 1 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-13 WARD)

2-FULL NAME Eliza Lee

(a) RESIDENCE NO. 819 McDonogh ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: black | 5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Nathan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 48 | Months — | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house wife

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Hawley Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Martha Batchen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Carolina

14 Informant Records.

(Address)

15 Filed 1 - 1930, 19.. Registrar C. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-30

17 I HEREBY CERTIFY, That I attended deceased from 10-26-, 1930, to 10-30-, 1930,

that I last saw h[er] alive on 10-30-, 1930,

and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Acute arthritis

Septicaemia - B. haem. Staphylococcus

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture

(Signed) Benj. M. Baker, Jr., M.D.

Oct. 30 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL Nov. 1 1930

20 UNDERTAKER Ida Snowden

ADDRESS 1708 E. Madison St.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61913

CERTIFICATE OF DEATH

129 E 61913

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3019 Chesterfield Ave. ST., 26-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John N. Heilman

(a) RESIDENCE NO. 3019 Chesterfield Ave. ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Heilman

DATE OF BIRTH (month, day, and year) May. 9, 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Conducter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railway

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Charles Heilman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant Mrs. Mary E. Heilman

(Address) 3019 Chesterfield Ave.

Filed C. HAMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930, to Oct 31, 1930.

that I last saw him alive on Oct 28, 1930.

and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis.
Myocardial Degeneration.
Chronic nephritis.

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Mitchell, M. D.

Oct 31 1930 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Nov. 3 1930

20 UNDERTAKER Joseph L. Cook

ADDRESS 1005 West Baltimore St

1-30—M. & T.—100 B—50L

E 61914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 61914

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 W. Redwood ST., 4-30 WARD)

2-FULL NAME Daniel F. Donoghue

(a) RESIDENCE NO 604 W. Redwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 8-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Donoghue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Connolly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mary Brennan
(Address) 121 S. Gilmor St

15 ..... 192 ..... Registrar

T930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Talbot M. D.
(Coroner)

10/31, 1930 (Address) 2-739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Nov. 3 1930

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61915 E 61915

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (NO. ..... ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Swindell Brosius

(a) RESIDENCE NO. 233 W. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? Lifrse mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced (Husband of or) WIFE of Everett Heath Brosius

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1876

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Williams Swindell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rachel Hough.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Marie B. Chamberlin (Daughter)
(Address) [illegible]

15 Filed ..... C. [illegible] Registrar

NOV 4

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1930, to Oct 31, 1930, that I last saw h[illegible] alive on Oct 31, 1930, and that death occurred, on the date stated above, at 3 23 P m.

The CAUSE OF DEATH* was as follows:

Coronary Acclusion

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic Pancreditis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home - of long standing

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Rudolph Schaefe, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hancock - Md. DATE OF BURIAL Nov 1, 1930

UNDERTAKER Stewart & Co. ADDRESS Balto

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61916 E 61916

CERTIFICATE OF DEATH.

88

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926- Hope St ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Enright Pitson

(a) RESIDENCE NO. 1926- Hope St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

6a If married, widowed, or divorced
HUSBAND) of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/26/1921

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	9	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) School.

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto Md

10 NAME OF FATHER Thomas Pitson

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma Mudgett

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto Md

PARENTS

14 Informant Mrs. Emma Pitson
(Address) 1926- Hope St

15 Filed NOV 2 1930, 19 E. K. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV-1-1930

17 I HEREBY CERTIFY, That I attended deceased from JULY 1st, 1930, to NOV-1-, 1930, that I last saw him alive on NOV-1-, 1930, and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

acute Dilatation Heart

(duration) X yrs. X mos 4 ds.

CONTRIBUTORY (Secondary) Subacute Endocarditis

(duration) X yrs. 4 mos. X ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of OCT 21-1930 Tonsils removed

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) Otto H Bucker, M. D.

NOV-1 1930 (Address) 928 E NORTH AV

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 11/4/30

20 UNDERTAKER George J. Roth-Inc

ADDRESS 1730 Harford

Spec.—1-30—M. & T.—250 Bks.

E 61917 HEALTH DEPARTMENT—CITY OF BALTIMORE

60-002

E 61917

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211- N. Calvert ST., 12-50 WARD)

2-FULL NAME Marcelina Boggess

(a) RESIDENCE NO. 2211- N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of Wm. B.F. Boggess

6b DATE OF BIRTH (month, day, and year) 3-6-1841

7 AGE: Years 89; Months 7; Days 25; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER James Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER Emma T. Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs. Adgett (Address) 2211 N. Calvert St

15 Filed 2-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29/30

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to Oct 29, 1930,

that I last saw her alive on Oct 29, 1930,

and that death occurred, on the date stated above, at 5-20 a m.

The CAUSE OF DEATH* was as follows:

I Hypostatic pneumonia

(duration) 2 wks yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? History & Clinical findings

(Signed) Wm. Gilbert, M. D.

10-30-00 19 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem.

DATE OF BURIAL 11/3/30 19

20 UNDERTAKER George J Butler Inc

ADDRESS 1705 Hoffman

1-30—M. & T.—100 B—50L

E 61918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 61918

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital St. 30 (WARD)

2-FULL NAME Henry Robert Schaefer

(a) RESIDENCE NO. 23 Taylor Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Augusta Schaefer

6 DATE OF BIRTH (month, day, and year) 4-30-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 66
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Louis Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. A. Schaefer

(Address) 23 - Taylor Ave

15 Filed ..... 1930 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Feller M. D.
Coroner

10/31, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem.

DATE OF BURIAL 11/2/30, 19

20 UNDERTAKER George J. Tuttle Jr Sons

ADDRESS 1235 Hanover

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61919

90 E 61919

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Poplar Grove St.) 16-68 (WARD)

2-FULL NAME Augusta Wilhelmina Behm

(a) RESIDENCE NO. 1519 Poplar Grove St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced (HUSBAND of or) WIFE of Paul R. Behm

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER ? Klinkert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

14 Informant Mrs Pauline A. Graf

(Address) 3035 Presstman St.

15 Filed 12-1930 By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930, to Nov 1st, 1930, that I last saw her alive on Nov 1st, 1930, and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) ....yrs. ....mos 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ....yrs. 1 mos. ....ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

19 (Address) 1900 Maryland ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 3, 1930

20 UNDERTAKER Wm Fackler Sons — ADDRESS North Ave

Spec.—1-30—M. & T.—250 Bks

E 61920

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61920

CERTIFICATE OF DEATH.

REGISTERED NO. 139

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 27-44 WARD)

2-FULL NAME Stella Becker

(a) RESIDENCE NO. 2807 Southern Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Becker

6 DATE OF BIRTH (month, day, and year): May 26, 1890

7 AGE — Years: 40 — Months: 5 — Days: 6 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

10 NAME OF FATHER: ? Erion

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr Albert Frank Becker

(Address) 2807 Southern Ave

15 Filed 2-1930 H. NELSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930, to Nov 1, 1930,

that I last saw her alive on Nov 1, 1930,

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Uterine fibroid

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Mesenteric thrombosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Ye Date of Oct 27, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Lis M Law, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cincinnati, Ohio

DATE OF BURIAL: Nov 2 1930

20 UNDERTAKER: Wm Huckner Sons.

ADDRESS: North Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61921

CERTIFICATE OF DEATH

143-003 E 61921

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bon. Secours Hosp. St., Ward)

2-FULL NAME Margaret E. Meadow Croft

(a) RESIDENCE NO. 1282 Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas H. Meadow Croft

6 DATE OF BIRTH (month, day, and year) Aug 7 - 1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	2	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER John Russell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Chas. H. Meadow Croft
(Address) 1282 Baltimore

Filed 2-1930 19.. H. Mason Long M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
Right dilatation of Heart
Following Pregnancy
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? .....
Did an operation precede death? Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Chas. H. Brooks M.D.
Oct 31, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cold Spring Cem — DATE OF BURIAL 11/3/30

20 UNDERTAKER Roger A Farley — ADDRESS Fulton & Fayette

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61922

REGISTERED NO. E 61922

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 4033 Fairfax ST. 15-15 WARD

2-FULL NAME Geo Vernon Hobbs.

(a) RESIDENCE NO. 4033 Fairfax ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ruth Hobbs

6 DATE OF BIRTH (month, day, and year): Aug 2-1899

7 AGE: Years 31; Months 2; Days 24; If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Elmer B. Hobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Marie Frantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ruth Hobbs

(Address) 4033 Fairfax Rd

15 Filed 6-2-1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] Coroner, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: Nov 3rd 1930

20 UNDERTAKER: Fureath Sypor

ADDRESS: 1600 W North Ave

Spec.—1-30—M. & T.—250 Bks

E 61923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 61923

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 N Central Ave ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah Jones

(a) RESIDENCE NO. 431 N Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

6a If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Leah Jones

6 DATE OF BIRTH (month, day, and year) June 12, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

057

9 BIRTHPLACE (city or town) (State or country) White Haven Md.

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Louise Wilson (daughter)

(Address) 431 N Central Ave

15 Filed 11-3-30 By Reg

Z 1401

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1930, to Nov 1, 1930, that I last saw h~~i~~m alive on Oct 31, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymat ous Nephritis

(duration) yrs. Couple mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Gosling, M. D.

11/1, 1930 (Address) 1439 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL White Haven Maryland

DATE OF BURIAL Nov 3 1930

20 UNDERTAKER Wm & Chas G Bailey 1421 Jefferson St

ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 61924

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 27-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Volkel

(a) RESIDENCE NO. 2913 Echodale Ave ST. Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

6a If married, widowed, or divorced (HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20/1860

7 AGE — Years: 70 Months: 1 Days: 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 2-1930 19 C. MARION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1-30

17 I HEREBY CERTIFY, That I attended deceased from 10-15, 1930, to 11-1, 1930, that I last saw her alive on 11-1, 1930, and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Probable Carcinoma Stomach

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Geyko, M. D.

11/1, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 3 1930

20 UNDERTAKER: Frederick Lassahn Sons — ADDRESS: 740 Adams Ave

Size—12-23-21—E.B.R.S.—400 Bks.

E 61925

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61925

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 925 n. Carey St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Johnson

(a) Residence No. 925 N. Carey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, Colored.

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Cora Johnson

6-DATE OF BIRTH (month, day and year) June 12, 1887

If LESS than 1 day, ...hrs. or.....min.?

7-AGE 33 yrs. 4 mos. 17 ds.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Howard Co Md

PARENTS

10-NAME OF FATHER. Wm Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). md

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). " "

11- (Informant) Cora Johnson.

(Address) 925 n. Carey St.

15- Filed 9-1930 THOMAS JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 29/30

17- I HEREBY CERTIFY, That I attended deceased from October 15 — 1930 to October 29 1930 that I last saw h~~im~~alive on October 28 — 1930 and that death occurred, on the date stated above, at 3-20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mns. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. Bunnell Fargo M. D.

, 19 (Address) 2937 N Calvert St City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cemetery

DATE OF BURIAL. Nov 2 1930

20-UNDERTAKER. Thomas E. Kelson

ADDRESS 1303 Pierstman St

Spec.—1-30—M. & T.—250 Bks

61926

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 61926

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T. B.) 15-22

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecil Taylor

(a) RESIDENCE NO. 1322 N. Gilmor st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) Feb. 4, 1909

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	8	25	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040
(c) Name of employer Unknown

10 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10 NAME OF FATHER David Taylor
11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia
12 MAIDEN NAME OF MOTHER Daisy Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Distric of Columbia

14 Informant Hospital Records
(Address)

15 Filed 11-3-30 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1930, to Oct. 29, 1930, that I last saw h im alive on Oct. 29, 1930, and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical & autopsy

(Signed) David Turner, M. D.
10-29, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reedville Va
DATE OF BURIAL NOV 2 1930

20 UNDERTAKER Thomas E. Kelson
ADDRESS 1803 Pennsylvania Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61927 — 91-002 — E 61927

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 23 ST. W WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. Scholaske

(a) RESIDENCE NO. 1430 Light ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Scholaske

7 DATE OF BIRTH (month, day, and year) Aug 28 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Friedrich Scholaske

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed Nov 2 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Oct 30, 1930, that I last saw him alive on Oct 30, 1930, and that death occurred, on the date stated above, at 7.00 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (Generalized) ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene Right foot

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert W. Elmendorf, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL Nov 3rd 1930

20 UNDERTAKER Leo S. Cook

ADDRESS 1723 Pratt Ave.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

61923 E 61923

CERTIFICATE OF DEATH.

61923 117

1-PLACE OF DEATH University Hospital REGISTERED NO. 27-46
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Lombard & Greene ST. WARD

2-FULL NAME George Sprowl (Stroul)

(a) RESIDENCE (No.) 5106 Reedy Ave. ST., Reading WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Mary E Pertner

6 DATE OF BIRTH (month, day, and year): Aug 17, 1872

7 AGE: Years 58 yrs | Months 2 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Hat Blocker
(c) Name of employer: Levy's

9 BIRTHPLACE (city or town) (State or country): Boston Mass.

PARENTS

10 NAME OF FATHER: Samuel Stroul

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baton Md.

12 MAIDEN NAME OF MOTHER: Ellen Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs Geo E Stroul (Address): 5106 Reedy Ave

15 Filed NOV 2 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Oct 31, 1930, that I last saw h[illegible]live on Oct - 31, 1930, and that death occurred, on the date stated above, at 5:40 p.m.

The CAUSE OF DEATH* was as follows:
Acute appendicitis

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary): Generalized Peritonitis
(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 27, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles F. Hill, M. D.

Oct 31, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Nov. 3 1930

20 UNDERTAKER: John A Moran — ADDRESS: 3000 E. Balto St.

Spec.—1-12-23—M&T—500 Blks.

E 61929

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61929

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH Jenkins Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1000 Caton Ave. ST. 27-48 WARD)

2-FULL NAME Michael F. Dougherty

(a) RESIDENCE NO. 714 Springfield Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 63 yrs. — Months: — Days: — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Dennis Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Calahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jenkins Memorial Hosp. (Address) 1000 Caton Avenue

15 Filed 2-1930 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from September 22 1930, to October 31. 1930, that I last saw him alive on October 31 1930 and that death occurred, on the date stated above, at 1.45 A.m.

The CAUSE OF DEATH* was as follows:

Hypertension Cardio Vascular Renal Disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hyalmar S. Anderson, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenbath Cem.

DATE OF BURIAL: 11/31/1930

20 UNDERTAKER: J. H. Horan

ADDRESS 3000 E Balto.

CLAYTON JONES, M.D.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61930 100-00 E 61930

CERTIFICATE OF DEATH

REGISTERED NO. 27-54

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. 2403 Everton Road ST. Mt. Washington WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard A. Miller, Sr.

(a) RESIDENCE NO. 2403 Everton Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Waller

DATE OF BIRTH (month, day, and year) July 4, 1845

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	3	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Jacob Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Bliss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont

14 Informant Mr. William E. Miller
(Address) 7 Beechdale Road

15 Filed NOV 2 - 1930 Harold Jones, M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/1/30

17 I HEREBY CERTIFY, That I attended deceased from 10/28, 1930, to 11/1, 1930,
that I last saw h[illegible] alive on 11/1, 1930
and that death occurred, on the date stated above, at 2 A [illegible] m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Pneumonia - Bronchopneumonia - Pleurisy.
(duration) yrs. 6 mos. 3 ds.

CONTRIBUTORY (Secondary) acute Myocardial failure (duration) yrs. mos. one hour ds.

18 Where was disease contracted if not at place of death? 2403 Everton Road

Did an operation precede death? No Date of

Was there an autopsy? No official test

What test confirmed diagnosis? Richard B. Morgan, M. D.

(Signed)

11/1, 1930 Address) 6 E. Read St. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov. 3, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Mahlon B. Mitchell

Spec.—8-24-14—M. & T.—2000 Bks.

E 61931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 61931

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gunning Sanitarium ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Julia D. Wright

(Residence in Baltimore: No. Gunning Sanitarium Farmer Md. 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct 27 (Month) (Day), 1866. (Year)

7-AGE,	If LESS than 1 day,
64 yrs. mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Ladies maid
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Aurora N.J.

PARENTS.

10-NAME OF FATHER, Edmund H. Wright

11-BIRTHPLACE OF FATHER (State or Country), Aurora N.J.

12-MAIDEN NAME OF MOTHER Sara Moore

13-BIRTHPLACE OF MOTHER (State or Country), U.S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) Hyattsville Md

15-

Filed ..... 192.. 191..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31 (Month) (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1906, to Oct 31 1930, that I saw h alive on Oct 31 1930, and that death occurred, on the date stated above, at 10:50 m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) 1 yrs. mos. ds.

(Signed) Alfred J. Cornelius M. D.

Oct 31, 1930. (Address) Aurora Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 24 yrs. 9 mos. 16 ds. In the State 24 yrs. 9 mos. 16 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 24 Aurora Ave Aurora Md.

19-PLACE OF BURIAL OR REMOVAL, Newark N.J. DATE OF BURIAL Nov 3, 1930

20-UNDERTAKER [illegible] ADDRESS [illegible]

NOV 2 - 1930

Spec.—1-30—M. & T.—250 Bks.

✓ E 61932

E 61932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 74-001

27-53

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5713 Roland Ave. ST. ..... WARD)

2-FULL NAME Emanuel Heyman

(a) RESIDENCE NO. Newark, N.J. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Blanche Heyman

6 DATE OF BIRTH (month, day, and year) Feby. 7, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary.

PARENTS

10 NAME OF FATHER ------ Heyman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary.

14 Informant Mr. Richard E. Kohn

(Address) Newark, N.J.

15 Filed ..... Registrar

V 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov 2, 1930,

that I last saw h.e alive on Nov 2, 1930,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ..... yrs. ..... mos 21 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage and Pulmonary oedema (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Julius Friedenwald, M. D.

, 19 (Address) 1013 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cemetery, Newark, N.J.

DATE OF BURIAL 11/2/ 1930

20 UNDERTAKER Maud Sondheim Son

ADDRESS 1903 Eutaw Place

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61933

E 61933

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4 E. 32nd St., Ward) 12-50

2-FULL NAME Bert C. Kuhlmann (KUHLMANN)

(a) RESIDENCE NO. 4 E. 32nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Kuhlmann

6 DATE OF BIRTH (month, day, and year) Oct 9th 1873

7 AGE Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
57	0	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer G. B. Ruffidda

9 BIRTHPLACE (city or town) Parkin Ill.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Kuhlman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Bouk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant (Address) Mabel Kuhlman 4 E. 32nd St

15 Filed NOV 2-1930 H. ROSS JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul H. Grossner, M. D.

11/2 1930 (Address) 2432 Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ridgewood New Jersey

DATE OF BURIAL 11/3/1930

ADDRESS

20 UNDERTAKER Tom Cook 1217 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61934 | REGISTERED NO. 47 E 61934

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1510 Hollins St. ST. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie M. Showacre

(a) RESIDENCE NO. 1510 Hollins St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1880.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Josiah S. Showacre

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John B. Showacre 1510 Hollins St.

15 Filed 1930 -1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1930, to Oct. 30, 1930, that I last saw her alive on Oct. 29, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of breast (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ..... Date of Oct. 21-30

Did an operation precede death? No.

Was there an autopsy? No.

What test confirmed diagnosis? Lab.

(Signed) Homer L. Todd, M. D.

11/1, 1930 (Address) 735 N. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL 11/3/30

20 UNDERTAKER Harry W. Witzke, 4101 Edmondson Ave ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61935

E. 61935

CERTIFICATE OF DEATH.

REGISTERED NO. 2553 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Upland Road (St.) Roland (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Myra Dodson Robinson

(a) RESIDENCE NO. Roland Park Apt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of: Edward L. Robinson.

6 DATE OF BIRTH (month, day, and year): Oct. 21, 1867

7 AGE: Years 63 Months 0 Days 11 If LESS than 1 day, hrs or min. 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Richard S. Dodson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co. Maryland

12 MAIDEN NAME OF MOTHER: Maria[illegible] Pfeltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Edward L. Robinson

(Address): Roland Park Apt.

15 Filed 3-1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 1, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1923. to Nov. 1 1930.

that I last saw her alive on Oct. 31, 1930.

and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) V. Boteman, M. D.

11-1 1930 (Address) 1107 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Nov 3rd 1930

20 UNDERTAKER: Henry Heuken & Co

ADDRESS: Orchard & Mulberry Sts.

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 61936

~~E~~ 61936

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST. 28-71 WARD)

2-FULL NAME Eugene Demarco

(a) RESIDENCE NO. 407 Kingston Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): —

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-31-30

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Franklin Square Hospital

PARENTS

10 NAME OF FATHER John Demarco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto -

12 MAIDEN NAME OF MOTHER Mary Johnson md.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Madonna

14 Informant Mary Demarco

(Address) 407 Kingston Rd.

15 Filed 19 Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31-30

17 I HEREBY CERTIFY, That I attended deceased from 10-31- , 1930, to 10-31 , 1930

that I last saw h— alive on 10 31 - 1930

and that death occurred, on the date stated above, at 9.23 P. m.

The CAUSE OF DEATH* was as follows:

Immaturity Birth

due to placenta previa

7½ mo -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) S Demarco M. D.

10-31 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19 1930

ADDRESS

20 UNDERTAKER

UNIVERSITY OF MARYLAND

Spec.—I-30—M. & T.—250 Bks.

E 61937 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61937

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General St. 21st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Nellie Brehm

(a) RESIDENCE NO. 847 Washington Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Theodore Brehm

6 DATE OF BIRTH (month, day, and year) April 16 - 1890

7 AGE	Years	Months	Days 16	If LESS than 1 day.....hrs. or.....min.
	70	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER James Parson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Molly McCoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant Mr Theodore M Brehm

(Address) 847 Washington Blvd

Filed 3 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2/1930

17 I HEREBY CERTIFY, That I attended deceased from 8/11/30, 19..., to 11/2, 19 30, that I last saw h. alive on 11/2, 19 30, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cardio - vascular renal disease with hypertension

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm F Sullivan M. D.

, 19 (Address) Balt Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 11/5/1930

ADDRESS

20 UNDERTAKER John F Cowan & Son

Spec—1-30—M. & T.—250 Bks.

100-001

61938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 61938

REGISTERED NO.

1-PLACE OF DEATH Bacto City Hospls

CITY OF BALTIMORE: (NO. 1 Balto md ST., 17-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Johnson (Hudson)

(a) RESIDENCE NO. 717 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Separated

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE — Years: 48 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waitress 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bacto City Hospls.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31-30

17 I HEREBY CERTIFY, That I attended deceased from 10-24-, 1930, to 10-31-, 1930

that I last saw h[illegible] alive on 10-31-, 1930

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm. Gladstone L. M. D.

11/1, 1930 (Address) 15 Bath Ave Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 11/5/1930

ADDRESS

20 UNDERTAKER Geo. H. Holland 1631 Druid Hill Ave

Spec.—2-29-28—L. F. S.—500 Bks.

Amelia Allen

HEALTH DEPARTMENT—CITY OF BALTIMORE

119

E 61939

CERTIFICATE OF DEATH

E 61939

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Allen, Amelia

(a) RESIDENCE NO. 2905 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. B. Allen

DATE OF BIRTH (month, day, and year) Sept. 14/96

AGE: Years 34 | Months 1 | Days 18 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

BIRTHPLACE (city or town) (State or country): City

10 NAME OF FATHER Chas. A. Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER Margaret Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Margaret Oliver

(Address) 2905 Fait ave

15 Filed 3-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2-30

17 I HEREBY CERTIFY, That I attended deceased from 9-26- 1930, to 11-2 1930, that I last saw her alive on 11-2 1930 and that death occurred, on the date stated above, at 7:18 A- m.

The CAUSE OF DEATH* was as follows:

Gangrene intestines

due to mesenteric thrombosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis, cardiac decompensation (duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? Franklin Square Hospital

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. B. Schreiber, M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem

DATE OF BURIAL: Nov. 5 1930

20 UNDERTAKER: Philip Hornig

ADDRESS 2016 Orleans St

Spec.—1-30—M. & T.—250 Bks

E 61940 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 61940

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3131 Pheasley Ave (4-11) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward S. Quarles

(a) RESIDENCE NO. 1712 Montpelier ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara D. Quarles

6 DATE OF BIRTH (month, day, and year): Nov 22 1855

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	11	10 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va.

PARENTS

10 NAME OF FATHER: Edmond Quarles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Augusta Crosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Clara D. Quarles

(Address): 1712 Montpelier st

15 Filed 3-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 2/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930, to Nov. 2, 1930, that I last saw him alive on Nov. 2, 1930, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 18 yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jesse S. Bishop, M. D.

, 19 (Address) 12 E - 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk.

DATE OF BURIAL: NOV 5 1930

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans st

Spec.—12-9-25—A Co.—200 Blks.

61941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-002 ✓ E. 61941

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3436 Chestnut Av. 13-53 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Kavanaugh

(a) RESIDENCE NO. 3436 Chestnut Av. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): (c)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: (c)

6 DATE OF BIRTH (month, day, and year): Nov 1-1930

7 AGE — Years | Months | Days: 1 | IF LESS than 1 day hrs. 6 or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: (c)

(b) General nature of industry, business, or establishment in which employed (or employer): (c)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

10 NAME OF FATHER: Joseph J Kavanaugh

11 BIRTHPLACE OF FATHER (city or town): Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER: Theresa V. Bostle

13 BIRTHPLACE OF MOTHER (city or town): Baltimore Md

(State or country)

14 Informant: Joseph J Kavanaugh

(Address) 3436 Chestnut Av

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 2, 1930;

that I last saw him alive on Nov 2, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Prematurity, Debility

Foramen Ovale not Closed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Flair, M. D.

, 19 (Address) 2704 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden

Date of Burial: Nov 3 1930

20 UNDERTAKER: Chesworth & Son

ADDRESS: 3415 Clarendon Av

FILED NOV 3 - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61942

CERTIFICATE OF DEATH

101-001

E. 61942

REGISTERED NO. 8-17

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 N. Gay St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jeanne M. Imsley.

(a) RESIDENCE NO. 1504 N. Gay St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Imsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Loretta Finnegan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elmira N. Y.

14 Informant Loretta Imsley

(Address) 1504 N. Gay St.

15 Filed 1930 C. J. Wm. Jones, M. D. Registrar

3-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1-1930

17 I HEREBY CERTIFY, That I attended deceased from 10-28, 1930, to 11-1, 1930.

that I last saw h[illegible] alive on 11-1, 1930

and that death occurred, on the date stated above, at 2300 m.

The CAUSE OF DEATH* was as follows:

acute lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) acute lobar pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) S. A. Simmons M. D.

11-4-30, 19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 3 1930

20 UNDERTAKER L. J. Rauch

ADDRESS 6405 Eastern

Spec.—1-30—M. & T.—250 Bks

E 61943

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 61943

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3309 Paton Ave. ST. 27-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Brinkley

(a) RESIDENCE NO. 3309 Paton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Robert Brinkley

6 DATE OF BIRTH (month, day, and year) May 15, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winchester Va.

PARENTS

10 NAME OF FATHER William Fractious

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winchester Va.

12 MAIDEN NAME OF MOTHER Lucy Armstead.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winchester Va

14 Informant Nancy Campbell

(Address) 3309 Paton Ave.

15 Filed 3-1930 16 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31/30.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28 , 19 30 , to Oct. 31 , 19 30 .

that I last saw her alive on Oct. 31 , 19 30 .

and that death occurred, on the date stated above, at 11:45a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) About 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 3 19 30
20 UNDERTAKER	ADDRESS
Samuel Hemsley	[illegible]

1-30—M. & T.—100 B—50L

E 61944

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61944

CERTIFICATE OF DEATH

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH 2215

CITY OF BALTIMORE: (No.) 2215 Chapelank ST., 1-3 WARD)

2-FULL NAME Edward Kinkel

(a) RESIDENCE NO 2215 Chapelank ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 16 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Infant Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Kinkel

11 BIRTHPLACE OF FATHER (city or town) Balto, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Frances Zimba

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Louis Kinkel
(Address) 2215 Chapelank St

15 Filed 3-1930, 192.. (THOMPSON JONES) Registrar
Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy History

(Signed) C C Wades, M. D.
Coroner

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Thomas Lane Cemetery	Nov. 3 1930.

20 UNDERTAKER George A. Weber. 705 Lanvale St

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 61945 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61945

113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 1-3 WARD)

2-FULL NAME Madeline Astrowska

(a) RESIDENCE NO. 2108 Cambridge ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22 1930

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Polish Original

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant [illegible]

(Address) [illegible]

15 Filed 3-[illegible]-1930 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-25, 1930, to 11-2, 1930, that I last saw h[illegible] alive on 11-2, 1930, and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (Type Undetermined)

(duration) [illegible] yrs. [illegible] mos 1 ds.

CONTRIBUTORY (Secondary) Septicemia - Staphylococcus Otitis media - Enteritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bl. Cult.

(Signed) J. C. Heuman, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Nov. 4 1930 — DATE OF BURIAL

20 UNDERTAKER John M. Wolfe & Sons — ADDRESS 1 W. Chase

Spec.—1-30—M. & T.—250 Bks.

E 61946

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61946

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 Cambridge St., ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Podulo

(a) RESIDENCE NO. 2316 Cambridge St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 27 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Podulo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER [illegible] Jarocki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant [illegible] Podulo

(Address) [illegible] Cambridge St.

15 Filed 3-1930 19 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 30 1930 to Nov 2 1930, that I last saw her alive on Nov 2 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Sepsis

(duration) ..... yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William F. Rydzewski M. D.

Nov 3 1930 (Address) 801 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem Nov. 3 1930

DATE OF BURIAL

20 UNDERTAKER John M Wolfe & Son

ADDRESS Chester

Spec.—1-30—M. & T.—250 Bks.

E 61947

E 61947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Ward ST. 21-28 WARD)

2-FULL NAME Sarah J Parker.

(a) RESIDENCE NO. 1413 Ward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Parker.

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 61 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md

12 MAIDEN NAME OF MOTHER: Nothmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Carrie Parker. (Address) 1413 Ward st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 26th, 1930, to Oct 31, 1930, that I last saw her alive on Oct 30, 1930, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry J Brown M. D.

11/2 1930 (Address) 1916 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Natural Cemetery.

DATE OF BURIAL: Nov. 5 1930

20 UNDERTAKER: Mrs Kate R Williams

ADDRESS 3221 Schroeder st

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61948

REGISTERED NO. 101-001

E 61948

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 W. Mulberry St ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Myers

(a) RESIDENCE NO. 734 W. Mulberry ST., 17 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Della Myers

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 50; Months; Days; If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): Unemployed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mt. Airy Maryland.

10 NAME OF FATHER: John Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Debby Risley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Arthur Myers

(Address): 1607 Darley Ave

15 FILED: NOV 3 - 1930. C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1930, to Oct 30, 1930, that I last saw him alive on Oct. 30, 1930, and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) ? (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Douglas Shepperd, M. D.

10/30, 1930 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ~~Mt~~, Auburn Cemetery

DATE OF BURIAL: Nov. 2, 1930

ADDRESS 3224 Schroeder St.

20 UNDERTAKER: Mrs. Katie R. Williams

c.—1-30—M. & T.—250 Blks

Buckalew

E 61949 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61949

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH University Hospital REGISTERED NO. 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) Lombard & Greene ST., WARD)

2-FULL NAME Ruth Dell Buckalew

(a) RESIDENCE NO. 3440 Leverton Ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

ength of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	White	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Feb. 3 1930

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	28	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Raymond Buckalew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Dick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Raymond Buckalew

(Address) 3440 Leverton Ave

Filed NOV 3 - 1930 HAMPSON Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1930, to Nov. 1, 1930, that I last saw h[illegible] alive on Nov. 1, 1930, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Fermentative Diarrhea

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George J. Snoops Jr. M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL G.H. Matthews Nov.

DATE OF BURIAL 4 1930

20 UNDERTAKER Jos. J. Burr

ADDRESS 156 N. Luzerne

Spec.—1-30—M. & T.—250 Bks

E 61950

E 61950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 915 Chauncey av ST., 7-13 WARD)

2-FULL NAME Rose Sokolow

(a) RESIDENCE No. 1045 N. Broadway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of ~~Harry~~ Simon Sokolow

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis 1439 Bank st

15 Filed 3-1930 19 M. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1925, to Nov 3rd, 1930 that I last saw her alive on Nov 3rd, 1930 and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Heart disease (mitral (cancer)

(duration) 5 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs Symptoms

(Signed) M. Chodesky, M. D.

19 (Address) 2225 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel

DATE OF BURIAL 11-3-1930

20 UNDERTAKER Max Louis, 1439 E Baltimore St.

ADDRESS

Spec.—I-30—M. & T.—250 Bks.

E 61951 ✓ E 61951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1029 Clay (ST.) 18-Mo (WARD)

2-FULL NAME Juanita Stewart

(a) RESIDENCE NO. 1029 Clay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-24-27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Howard Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Lillie Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Helen Parker

(Address) 1029 Clay St

15 Filed Dec 3 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1-30

17 I HEREBY CERTIFY, That I attended deceased from 10-21, 1930, to 11-1, 1930, that I last saw her alive on 10-31-30, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Mace Williams, M. D.

11-2 1930 (Address) 1730 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Nov 4, 1930

20 UNDERTAKER Mrs. Katie R Williams

ADDRESS 3221 Schroeder St.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61952

CERTIFICATE OF DEATH.

E 61952

REGISTERED NO. 91-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1321 E. Eager ST. 10-14 WARD)

2-FULL NAME Sophia Haenig

(a) RESIDENCE NO. 1321 E Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Stephen Haenig

6 DATE OF BIRTH (month, day, and year) February 13 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER M. Eisling

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known

(State or country)

14 Informant Mrs Conrad O Thellmann

(Address) 1321 E Eager St

15 Filed 1930 H. HAMDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1930, to Nov 3d, 1930, that I last saw h[er] alive on Nov 1st, 1930, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

a Hydro Pleurosis

Contributory Days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H O Stone M. D.

, 1930 (Address) 4900 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Nov. 6 1930

20 UNDERTAKER Henry Koeck Sons Inc. ADDRESS 1301 E. Eager St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 61953

REGISTERED NO.

E 61953

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. ST. 76-39 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aloysius Suchebradl

(a) RESIDENCE NO. 903 N. Eric St. STREET Orangeville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records Of (Address) BALTIMORE CITY HOSPITALS

15 Filed Nov. 4 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1930, to Nov. 1, 1930, that I last saw him alive on Nov 1, 1930, and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease, arteriosclerotic

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padgett, M. D.

11-2 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Nov. 4 1930

20 UNDERTAKER Henry Hoeck Sons, Inc. — ADDRESS 137 E Eager St

Spec.—1-30—M. & T.—250 Bks

E 61954

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

CERTIFICATE OF DEATH.

REGISTERED NO. E 61954

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3206 O'Donnell St. 76-1 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Robinson

(a) RESIDENCE (Usual place of abode) NO. 3206 O'Donnell ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Mary E. Robinson

6 DATE OF BIRTH (month, day, and year) Feb. 22. 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	8	11 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Merchant (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary E. Robinson (Address) 3206 O'Donnell St.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15th, 1930, to Nov. 2nd, 1930, that I last saw him alive on Nov 2nd, 1930, and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) — yrs. — mos 18 da.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) David W. Jones, M. D.

11/3/1930 (Address) 1011 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL Nov. 5 1930

20 UNDERTAKER George W. Zibler

ADDRESS 1737 E. Eager St

Spec.—1-30—M. & T.—250 Bks.

E 61955 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

REGISTERED NO. E 61955

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 Harford Ave St. 10-14 WARD)

2-FULL NAME Julia Marcus

(a) RESIDENCE NO. 837 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Henry Marcus

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Orangeburg (State or country) S. C.

PARENTS

10 NAME OF FATHER John Ryder

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C

12 MAIDEN NAME OF MOTHER Julia Ryder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C

14 Informant Maggie Fields

(Address) 837 Harford Ave

15 Filed 3-1930 19 C. HAZLEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Oct 1, 1930,

that I last saw h alive on Oct 31 1930,

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis-Uterus

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (durstion) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Jno S Adler, M. D.

Nov 3 1930 (Address) 508 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 11-4 1930

20 UNDERTAKER Byron Wright 1218 McElderry St

ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61956

CERTIFICATE OF DEATH

E 61956

1—PLACE OF DEATH Maryland General Hospital REGISTERED NO. 113

CITY OF BALTIMORE: (No. ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Smitherman

(a) RESIDENCE NO. Odenton Maryland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20 1930

7 AGE: Years | Months: 3 | Days: 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER George Smitherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Louise Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Md.

14 Informant Hospital Record

(Address)

FILED DEC 3 - 1930 H. M. [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/1/30

17 I HEREBY CERTIFY, That I attended deceased from September 9, 1930, to November 1, 1930, that I last saw h/al alive on November 1, 1930 and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Pyloric Stenosis

Acute Gastro Enteritis

(duration) yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) John F. Clements, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: 11/3/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 61957 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E. 61952

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2544 Harford av ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME adolph DeLuca

(a) RESIDENCE NO. 2544 Harford a ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph DeLuca

6 DATE OF BIRTH (month, day, and year) Aug 4 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Self - 604

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER August DeLuca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank DeLuca

(Address) 1829 - 28th St

15 Filed 19 Registrar

H. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 2 - 30.

17 I HEREBY CERTIFY, That I attended deceased from 10 - 2 - 30 19 ... to 11 - 2 - 30 19 30.

that I last saw h[illegible] alive on 11 - 2 - 30 19 30

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B. - 1

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary T. B.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? nr Date of

Was there an autopsy? nr

What test confirmed diagnosis? Clinical

(Signed) S. Simard M. D.

11-4 19 30 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov 4 1930

20 UNDERTAKER Frank V. Sipitone

ADDRESS 2818 E. Balto st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61958 ✓ X 123 E 61958

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST. 11-74 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME General Willis

(a) RESIDENCE NO. Owings Mills, Md. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 22 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chestertown Md.

10 NAME OF FATHER: Edward Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chestertown Md.

12 MAIDEN NAME OF MOTHER: Mary Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital records

(Address)

15 Filed 11-3-1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 2/1930

17 I HEREBY CERTIFY, That I attended deceased from 10-22-1930, to 11-2-1930, that I last saw her alive on 11-2-1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis
Cholelithiasis

5-7 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 10-25-30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Robert F. Chenault, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Nov. 5 1930

20 UNDERTAKER: Chas. E. Franck — ADDRESS: 802 Madison Ave

Spec.—1-30—M. & T.—250 Bks.

242186

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-00

E 61959

E 61959

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 26-36 WARD)

2-FULL NAME Marie Keller

(a) RESIDENCE NO. 6556 Cornell ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wm Keller

6 DATE OF BIRTH (month, day, and year) Mar-10-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N.W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Novak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 11-3-1930 E. H. Mayo JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov 3, 1930, that I last saw her alive on Nov 3, 1930, and that death occurred, on the date stated above, at 335A m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

malignant (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Calvert Hundley, M. D.

11/3, 1930 (Address) J H Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 11-6 1930

20 UNDERTAKER Albert L Nill Jr 1606 N Chester

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

61960 90 E 61960

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 E 22nd ST. 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Webster Stuart

(a) RESIDENCE NO. 200 E 22nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11/1852

7 AGE: Years 78 Months 6 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Charles A Stuart

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Emily M Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Warner L Stuart

(Address) 200 E 22nd St

Filed NOV 3 - 1930 H. [illegible] JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2/1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Nov 2, 1930

that I last saw h[illegible] alive on Nov 1st, 1930

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical sign

(Signed) W H Keech M. D.

Nov 2 1930 (Address) 2105 Charles

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Nov 4 1930

20 UNDERTAKER: Berkman & Garfinkle — ADDRESS: 1122 W Lafayette Ave

Spec.—1-30—M. & T.—250 Bks.

24219 8

E 61961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001

E 61961

REGISTERED NO.

1.—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2.—FULL NAME William Ponnoie

(a) RESIDENCE NO. 1033 Hillman ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) not

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Loretta Ponnoie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antonetta Gonsalves

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Friends-

(Address) JOHNS HOPKINS HOSPITAL

19 Registered by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. -1-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov. 1, 1930, that I last saw h[illegible]alive on Nov. 1, 1930, and that death occurred, on the date stated above, at 9 a- m.

The CAUSE OF DEATH* was as follows: Pneumococcus Meningitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal Puncture

(Signed) H. O. Warren, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Nov 3. 1930

20 UNDERTAKER Wendell & Cignal ADDRESS 3rd & Columbia

Spec.—1-30—M. & T.—250 Bks.

E 61962

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61962

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Johnson ST. 24-34 WARD)

2-FULL NAME John. T. Higdon

(a) RESIDENCE NO. 1734 Johnson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Alice T. Higdon

6 DATE OF BIRTH (month, day, and year) Oct. 7/1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John. T. Higdon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth E. Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alice T. Higdon
(Address) 1734 Johnson St.

15 Dec 3- 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2/1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1930, to Nov. 2, 1930, that I last saw him alive on Nov. 2, 1930 and that death occurred, on the date stated above, at 11:55 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) Indefinite yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. L. Campbell, M. D.

11/3, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov. 5 1930

20 UNDERTAKER J. Walter Davis ADDRESS 3418 Chestnut Ave.

Spec.—12-23-2—E.B.R.S.—400 lks.

E 61963

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 61963

CERTIFICATE OF DEATH.

Registered No. 26-11 100-001

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3216 Mc Elderry St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alphonse J. Lang

(a) Residence No. 3216 Mc Elderry St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Agnes M Lang

6-DATE OF BIRTH (month, day and year): Sept 24 1876

7-AGE: 54 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer): Plumber

(c) Name of employer: Self

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS

10-NAME OF FATHER: Michael Lang

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Catherine Fultz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md

14 (Informant): Agnes M. Lang (wife)

(Address): 3216 McElderry

15- Filed ....., 1930 C. HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 31 1930

17- I HEREBY CERTIFY, That I attended deceased from Oct 28, 1930 to Oct 31, 1930

that I last saw him alive on Oct 31, 1930

and that death occurred, on the date stated above, at 5- A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) O. L. Long M. D.

(Address) 1711 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Nov. 4, 1930

20-UNDERTAKER: Henry Sander & Sons Inc

ADDRESS: Baltimore St & Broadway

Spec.—1-30—M. & T.—250 Bks

E 61964 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61964

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Sample

(a) RESIDENCE NO. 267 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mattie Sample

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Hampton Co. Va.

PARENTS

10 NAME OF FATHER Elijah Sample

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Louella Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Balto. City Hosp.

Filed 3-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28-30

17 I HEREBY CERTIFY, That I attended deceased from 10-19-30, 19 to 10-28-30, 19, that I last saw him alive on 10-28-30, 19, and that death occurred, on the date stated above, at 9:25 P m.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic, with edema.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam. Lab.

(Signed) Paul Podgil, M. D.

11-1, 1930, (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL NOV 3 1930

20 UNDERTAKER

ADDRESS

L. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks

E 61965

HEALTH DEPARTMENT—CITY OF BALTIMORE E 61965

CERTIFICATE OF DEATH.

74-001 REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 5-8 WARD)

CITY OF BALTIMORE: (No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Johnson

(a) RESIDENCE NO. Low & Exeter ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) Mar. 28, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charlottesville (State or country) Va.

PARENTS

10 NAME OF FATHER Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emilie Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Baltimore City Hospitals

Filed 11-3-1930, 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31-30

17 I HEREBY CERTIFY, That I attended deceased from 10-27-30, 19 to 10-31-30, 19

that I last saw him alive on 10-31-30, 19

and that death occurred, on the date stated above, at 8:05 Am.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Hypertension UNKNOWN (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

11-1, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

UNIVERSITY OF MARYLAND

NOV 3 1930

Spec.—1-30—M. & T.—250 Bks.

E 61966 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61966

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., (Ward) 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Livingston

(a) RESIDENCE NO. 2705 Overland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-1-30

7 AGE	Years	Months	Days	If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Stanley Orville Livingston

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Alberta Stevenson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Hospital Records
(Address)

Filed NOV -1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 at 10 A.M., 1930, to Nov. 1, at 5 P.m., 1930,

that I last saw h[illegible] alive on Nov. 1 at 5 P.m., 1930,

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Premature child - 6 months

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Eclampsia Mother

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov. 1, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Kohn's State Board

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

NOV 3 1930

Commissioner of Health.

Spec.—1-30—M. & T.—250 Bks

E. 61967

HEALTH DEPARTMENT—CITY OF BALTIMORE E. 61967

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 S. Conkling ST. 26-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Getz

(a) RESIDENCE NO. 206 S. Conkling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Getz

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George G. King (Address) 206 S. Conkling St.

15 Filed NOV 5 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1930, to Nov 3 - 19 1930

that I last saw h. alive on Nov 3 - 19 1930

and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Acute edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 3 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Physical

(Signed) Laurence B. Sheldon, M. D.

, 19 (Address) 807 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Nov. 5 1930

20 UNDERTAKER Mrs. C. Miller & Son

ADDRESS 2334 Jefferson St.

Spec.—1-30—M. & T.—250 Bks.

E 61968

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61968

CERTIFICATE OF DEATH.

21

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hosp (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 6-10 ST., WARD)

2-FULL NAME John Haug

(a) RESIDENCE NO. 705 N. Ross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1889 —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.:
	41	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Haug ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Friends Address Baltimore City Hosp.

15 Filed 3-1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1-30

17 I HEREBY CERTIFY, That I attended deceased from 2-18-1930, to 11-1-1930, that I last saw h— alive on 11-1-1930, and that death occurred, on the date stated above, at 10:55 A. m.

The CAUSE OF DEATH* was as follows:

Empyaema left pleural Cavity

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 10-17-30

Was there an autopsy? no

What test confirmed diagnosis? clinical exp.

(Signed) Paul M. Dunkenfield, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem

DATE OF BURIAL Nov. 4 1930

20 UNDERTAKER Wm. E. Miller & Son

ADDRESS 2334 Jefferson St.

Spec—1-30—M. & T.—250 Blks.

E 61969 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61969

44

CERTIFICATE OF DEATH.

REGISTERED NO. 28463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael McCarthy

(a) RESIDENCE NO. Mount Hope Retreat ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or WIFE) of Mrs McCarthy

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	58	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Cigars 017

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md -

PARENTS

10 NAME OF FATHER Michael McCarthy

11 BIRTHPLACE OF FATHER (city or town) Cork (State or country) Ireland

12 MAIDEN NAME OF MOTHER Isabel O Hara

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland

14 Informant Records of Mt. Hope (Address) Mt Hope Retreat -

15 Filed 19 [illegible] Registrar

3-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3-d 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1918, to Nov 3rd 30, 19, that I last saw living on Nov 2nd, 1930, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows: —

Carcinoma of Stomach

abt (duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Melancholia

abt (duration) 12 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? Yes -

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Nov 3rd, 1930 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer. DATE OF BURIAL Nov. 6 1930

20 UNDERTAKER George W. Zirkel ADDRESS 1737 Eager St

Spec. 2-29-28—L. F. S.—500 Bks.

E 61970

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61970

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH West Baltimore General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 7-7-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Smith

(a) RESIDENCE NO. 700 Springfield Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Smith

6 DATE OF BIRTH (month, day, and year) Feb 8 1873

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTAGE

10 NAME OF FATHER John Courtney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Marcella Moore

(Address) 1213 E. Fountain.

15 Filed 1-4 1930 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 25. 1930. to Nov. 1 . 19 ; that I last saw h alive on Nov. 1 . 19 ; and that death occurred, on the date stated above, at 4:25 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with Terminal Uraemia

(duration) unknown mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) H. Cohnman, M. D.

(Address) West Balto Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 1/4/1930

20 UNDERTAKER J. G. Moran

ADDRESS E. Baltimore

Spec.—I-30—M. & T.—250 Bks.

E 61971 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61971

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 732 W. Fayette ST., (8-16 WARD)

2-FULL NAME Louise E. Berlin

(a) RESIDENCE NO. 732 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of George Berlin

6 DATE OF BIRTH (month, day, and year) [illegible] 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Kirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George W. Berlin

(Address) Easton, Md.

15 Filed 3-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Nov. 6, 1930,

that I last saw h[illegible] alive on Nov. 6, 1930.

and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Nov 13, 1930 (Address) 481 S. Gammon Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Nov. 4, 1930

20 UNDERTAKER Easton Home ADDRESS Elliott City

Spec.—1-30—M. & T.—250 Bks.

E 61972

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61972

CERTIFICATE OF DEATH.

129

REGISTERED NO. 12432

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. So. Balt. Gen Hosp ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas N. Davis

(a) RESIDENCE NO. 111 West Fort ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Lillian R. Davis

6 DATE OF BIRTH (month, day, and year) Dec 26-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	10	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9 BIRTHPLACE (city or town) Essex Co. Md
(State or country)

PARENTS
10 NAME OF FATHER Samuel Davis
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Essex Co. Md
12 MAIDEN NAME OF MOTHER don't know
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Essex Co. Md

14 Informant Thomas N. Davis Jr
(Address) 103-4 ave Brooklyn Md

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar
3-1930 Paid ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2/1930 - 10 A.M.

17 I HEREBY CERTIFY, That I attended deceased from
Oct 28, 1930, to Nov 2, 1930,
that I last saw h.. alive on Nov 2, 1930,
and that death occurred, on the date stated above, at 10 30 a.m.
The CAUSE OF DEATH* was as follows:
Chronic nephritis
(Interstitial)
many
(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) uraemia
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Wm L. Sullivan M. D.
, 19 (Address) So Balt Genl Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lappahannock Essex Co Va
DATE OF BURIAL Nov. 4 1930

20 UNDERTAKER A. Howard Evans
ADDRESS 38 E Fort Ave

1-30—M. & T.—100 B—50L

Crouch ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61973

E 61973

CERTIFICATE OF DEATH

× 57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST., 7-9 WARD)

2-FULL NAME Ethel Hopkins Crouch

(a) RESIDENCE NO Chase, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of Robert M. Crouch
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 22/1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	44	2	3 9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elkton, Md.

PARENTS

10 NAME OF FATHER Robt. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elkton, Md.

12 MAIDEN NAME OF MOTHER Jane Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elkton, Md

14 Informant Mr. Robert Crouch
(Address) Chase, Md.

15 Filed ..... 193 C. HAMPSON JONES, M. D.
3 - 1930 Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) C. H. Jones, M. D.
Coroner

Nov. 3/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md

DATE OF BURIAL Nov 3 1930

20 UNDERTAKER Hughes Jones Inc

ADDRESS 1 W Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

E 61974

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61974

CERTIFICATE OF DEATH

11-001

REGISTERED NO. 27-53

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 505 Edgevale Road ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Tabitha Joynes Hance

(a) RESIDENCE NO. 505 Edgevale ~~road~~ Roland Park WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel B. Hance

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co. Va.

PARENTS

10 NAME OF FATHER Tulley A. Joynes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sabra B. Fitchett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Chas Coit

(Address) Norwich Conn.

15 Filed 3-1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-27, 1930, to Nov. 1, 1930, that I last saw h.e alive on Nov 1, 1930 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Influenza and Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pneumococcus

(Signed) M. Talbot Taylor, M. D.

11/2, 1930 (Address) 622 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov. 4. 1930

20 UNDERTAKER John O. Mitchell & sons

ADDRESS 1900 Eutaw Place

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61975

CERTIFICATE OF DEATH

E 61975

REGISTERED NO. 44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Tuscany Aparts. ~~Clarence M. Pitt~~ ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence M. Pitt

(a) RESIDENCE NO. Tuscany Apartments ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Wham Pitt

6 DATE OF BIRTH (month, day, and year): May 22 1862

7 AGE: Years 67 | Months 5 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: President of 045

(b) General nature of industry, business, or establishment in which employed (or employer): Bakwrs & confectioners Supplies

(c) Name of employer: Balto. md. Ba timore Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Unknown "

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: C. Blake Pitt

(Address): 407 Kensington Road

15 Filed NOV 3 - 1930 19 H. M. Parks Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2.1930

17 I HEREBY CERTIFY, That I attended deceased from August 4, 1930, to Nov. 2, 1930, that I last saw him alive on Nov 1st, 1930 and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray - hematemesis - Physical examination

(Signed) A Chinoffs, M. D.

19 (Address) 24 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Nov 4.1930 19

20 UNDERTAKER: John O. Mitchell & Sons

ADDRESS: 1900 Eutaw Place

John O. Mitchell & Sons

Spec.—1-30—M. & T.—250 Bks.

E 61976 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61976

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH U. S. Marine Hospital,

CITY OF BALTIMORE: (No. Baltimore, Maryland ST. 23-31 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alex Doukas

(a) RESIDENCE NO. 1022 Light St., Baltimore, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
20		8	20	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A.B.Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) SS Winona County

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk, Va.
(State or country)

PARENTS

10 NAME OF FATHER George Doukas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Greece

12 MAIDEN NAME OF MOTHER Helen ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Greece

14 Informant Records, U.S.Marine Hospital
(Address) Baltimore, Maryland

15 [illegible] 19 [illegible] Registrar

NOV 3 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1930, to November 1, 1930, that I last saw him alive on November 1, 1930, and that death occurred, on the date stated above, at 2:35 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, active.

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gordon A. Abbott, M. D.

, 19 (Address) U.S. Marine Hospital, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery — DATE OF BURIAL Nov. 4, 1930

20 UNDERTAKER E. LeRoy Stiffler, Inc. — ADDRESS 125 E. North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61977

90 E 61977

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2232 Barclay St. 12-50 Ward)

2-FULL NAME Lucia E. Snyder

(a) RESIDENCE NO. 2232 Barclay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Snyder

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland.

PARENTS

10 NAME OF FATHER James Wood

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah McKewin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Mrs. Murray
(Address) 733 Springfield Ave

C. H. SMITH JONES M. D.
Registrar

Filed ..... 19 .....

3-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jaundice Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Earl Hosselman, M. D.

11/3, 1930 (Address) 36 32 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Nov. 4, 1930

20 UNDERTAKER E. LeRoy Stifflen, Inc

ADDRESS 125 E. North Ave

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 61978

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61978

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Carswell ST., 9-46 WARD)

2-FULL NAME George F. Unverzagt

(a) RESIDENCE NO. 1709 Carswell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Margaret A. Unverzagt

6 DATE OF BIRTH (month, day, and year) Aug 27. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	2.	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Aug Unverzagt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Unverzagt

(Address) 1709 Carswell St

15 3 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930, to Nov 1, 1930, that I last saw h[illegible] alive on Oct 31, 1930, and that death occurred, on the date stated above, at 6 45 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J. Kinsey M. D.

11 Nov. 19 (Address) 2700 Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Nov 4 1930

20 UNDERTAKER J. E. Wooden Undertaker

ADDRESS 2008 Calvert

Spec.—1-30—M. & T.—250 Bks.

E 61979

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61979

CERTIFICATE OF DEATH.

10

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 7-11 WARD)

2-FULL NAME Harry Schwartz

(a) RESIDENCE NO. 612 No. Patonas ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Schwartz

6 DATE OF BIRTH (month, day, and year) Sept 17 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	1	16	

8 OCCUPATION OF DECEASED Accountant 009

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Schenderberg & Kunde Baltimore, Md.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Schwartz

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Mrs Virginia Schwartz
(Address) 612 N Patonas Baltimore

15 - F - 1930 Dec 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Nov. 3, 1930, that I last saw h alive on Nov. 3, 1930, and that death occurred, on the date stated above, at 4 10 a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) 0 yrs. 0 mos 28 ds.

CONTRIBUTORY (Secondary) Tonsilla Diphtheria

(duration) 0 yrs. 0 mos. 10 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) I. Peter Weverstein M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Nov 5th 1930

20 UNDERTAKER Doka Allred

ADDRESS 2008 Orleans

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61980

E 61980

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 S Caroline ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Scott.

(a) RESIDENCE NO. 231 S Caroline ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced (or) WIFE of: Martha Scott.

6 DATE OF BIRTH (month, day, and year): May 29 1875

7 AGE: Years 53. Months 5 6. Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver, Ice

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: John Scott.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eastern Shore.

12 MAIDEN NAME OF MOTHER: Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Tennessee

14 Informant: Martha Scott.

(Address) 231 S. Caroline St.

Filed 1930 19 H. LAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 19 30 to Nov 2 19 30.

that I last saw him alive on Nov 2 19 30

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 0 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Cardiac Dropsy

(duration) 2 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Edward Fisher, M. D.

19 (Address) 1212 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Grove Cem

DATE OF BURIAL: Nov. 3, 19 30

20 UNDERTAKER: Handel & Keppel

ADDRESS: 3004 Eden St.

Spec.—1-30—M. & T.—250 Bks

E 61981 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61981

CERTIFICATE OF DEATH. REGISTERED NO. 129

1-PLACE OF DEATH Jenkins Memorial Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1000 Caton Ave ST. 15-58 (WARD)

2-FULL NAME Charles F. Crawford

(a) RESIDENCE NO. 2616 Oswego Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Daughterty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Gertrude Crawford (Address) 2616 Oswego Ave.

Filed 3-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1930, to Nov. 1, 1930, that I last saw h[illegible] alive on Nov. 1, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic C. V. D.

Hemiplegia

(duration) Several yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hyalmar S. Anderson M. D.

(Address) St Agnes Hospital. 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Cem. Westminster

DATE OF BURIAL 11/4/30 19

20 UNDERTAKER Harry A. Kuitzke ADDRESS 4101 Edmondson Ave

Spec.—1-10-21—M&T—1500 Bks.

E 61982

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61982

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1917 W. Lombard St. ST., 20-28 (WARD)

2-FULL NAME George L. Murray

(a) RESIDENCE NO. 1917 W. Lombard St. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mamie J.(nee Huntt)

6 DATE OF BIRTH (month, day, and year) Nov. 3, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) Mail car 078

(c) Name of employer United Railways

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Myrtle I. Conrades (Address) 1917 W. Lombard st.

15 - 1930 C. EMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to Nov 1-st, 1930, that I last saw living alive on Nov 1st, 1930, and that death occurred, on the date stated above, at 11-P m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

Primal (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of /

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) E. E. Burton M. D.

11/3, 1930 (Address) 301 East 20th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11/5/30

UNDERTAKER Harry H. Witzke ADDRESS 4101 Edmondson Ave

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61983 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61983

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 E Center ST. 11-7 WARD)

2-FULL NAME Samuel K George

(a) RESIDENCE NO. 17 E Center St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate L George

6 DATE OF BIRTH (month, day, and year) 2, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Phillip I George

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Ellen Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Richard A Dugan

(Address) 1011 Monument

Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 3, 1930, that I last saw him alive on Nov 1, 1930, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia (terminal)

(duration) 0 yrs. 0 mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) many yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Norbrun Strauss, M. D.

, 19 (Address) 7 Park Ave Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dunbar Methodist

DATE OF BURIAL 11/4 1930

20 UNDERTAKER Wilson Co Inc

ADDRESS 15 W Saratoga St

C. HUNTER JONES, M. D.

Spec.—1-30—M. & T.—250 Bks

E 61984 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61984

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 24-33 ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John S. Hammond

(a) RESIDENCE NO. 1140 Riverside Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Molly

6 DATE OF BIRTH (month, day, and year) May 19, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katie Horney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records of Balto. City Hospitals

Filed 3-1930 C. H. ARNOLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from 9-2-30, 19 , to 11-3-30, 19 , that I last saw him alive on 11-3-30, 19 , and that death occurred, on the date stated above, at 1:20 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, with oedema.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, + Hypertension (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam; lab-

(Signed) Paul Padget. M. D.

11-3-1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 11/6/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt St

Cor.—12-9-25—A Co.—200 Bks.

E 61985

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61985

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) St Joseph Hospital St., 8-17 Ward)

2-FULL NAME Henry C. Elder

(a) RESIDENCE NO. 1413 E Federal St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie V. Elder

6 DATE OF BIRTH (month, day, and year): June 30, 1864

7 AGE — Years: 66 Months: 4 Days: 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Elder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sarah Litsinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Carrie V. Elder 1413 E Federal St

15 [illegible] 19[illegible] C. HAMPSON JONES, M. D., Registrar

3-1930 Per [illegible]

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck & knocked down by moving auto

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

Nov 1, 1930 (Address) 3934 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where did disease contracted, if not at place of death? Squirrel St Federal

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

Date of Burial: 11/4/1930

20 UNDERTAKER: Wilson Cook

ADDRESS: 1219 E Fayette

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61986

90

E 61986

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1216 Division ST. 17-24 WARD)

2-FULL NAME George White.

(a) RESIDENCE NO. 1216 Division ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	widower

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Rosie Cole
(Address) 1216 Division St

15 Filed NOV 4 1930 1939 H. M. SMITH COATS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1930, to Nov. 3, 1930, that I last saw h— alive on Nov. 3, 1930, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis,

(duration) — yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam &c

(Signed) Thos. Watkins, M. D.

11/3, 1930 (Address) 838 Dromedary St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL 11-4 1930

20 UNDERTAKER Arnold Eichen

ADDRESS 916 Bond

Spec.—1-30—M. & T.—250 Bks.

240811

E 61987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131 E 61987

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Priscilla Lee

(a) RESIDENCE NO. 1425 Bruce St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13 1894

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed V 4 1930 H. H. M. JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1930, to Nov. 1, 1930, that I last saw her alive on Nov. 1, 1930, and that death occurred, on the date stated above, at 11 10 a m.

The CAUSE OF DEATH* was as follows:

Uremia (7 days) due to Pyelonephritis

Myomata uteri - Cystitis -

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myomata uteri

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Culture - Pathalogical Blood Chemistry - H. S. Everett, M. D.

(Signed)

11/2, 1930 (Address) The Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Thomas Cem

DATE OF BURIAL 11-4-1930

20 UNDERTAKER David Taylor

ADDRESS 916 Cy ave.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61988

E 61988

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2430 Madison Ave St.) 13-54 (WARD)

2-FULL NAME Romulus J Curry

(a) RESIDENCE NO. 2430 Madison Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Anne Curry

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Eugene Curry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Wyatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Anne Curry
(Address) 2430 madison ave

NOV 4 - 1930

Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1/30

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to Nov 1, 1930, that I last saw h[redacted] alive on Nov 1, 1930, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) ..... yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease co[redacted] If not at place of deat[redacted] no Date of .....

Did an operation precede d[redacted]

Was there an autopsy? no

What test confirmed diagnosis? H S McCard M. D.

(Signed) .....

11/1, 1930 Address) 2029 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Grave Yard

DATE OF BURIAL Nov 11-4 1930

20 UNDERTAKER Dennis Funeral

ADDRESS 916 Eutaw

Spec.—1-30—M. & T.—250 Bks.

E 61989 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61989

CERTIFICATE OF DEATH.

REGISTERED NO. 160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. ST., 1824 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Baby) Percy Washington

(a) RESIDENCE NO. 314-W. Hoffman ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 16, 1930

7 AGE Years — Months — Days 17 / 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Percy Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York City

12 MAIDEN NAME OF MOTHER Bessie Maiben

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant 314-W. Hoffman (Address)

15 Filed 1930 C. H. Irvin JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-16-30, 19..... to 11-3-30, 19.....

that I last saw him alive on 11-3-30, 19.....

and that death occurred, on the date stated above, at 10:05 a.m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. B. Butler, M.D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Nov. 3 1930

20 UNDERTAKER Jesse D. Redden — ADDRESS 436 N. Biddle St

Spec.—1-30—M. & T.—250 Bks

E 61990

E 61990 HEALTH DEPARTMENT—CITY OF BALTIMORE

30

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 22-30 ST. WARD)

2-FULL NAME Phillip Joynes

(a) RESIDENCE NO. 110 W. Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Amer. Sugar Refinery

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Croxton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed NOV 4 - 1930 C. HILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from 10-23-30, 19, to 11-3-30 19, that I last saw h. alive on 11-3-30, 19, and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Nocardiosis (Streptothrycosis) of lungs.

(duration) more than yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Alcoholism, chronic (duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Town

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic & exam. lab.

(Signed) Paul Padget. M. D.

(-3, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11/5/30

UNDERTAKER Isaiah L Brown Son

ADDRESS 708 W Monument

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61991

CERTIFICATE OF DEATH.

118-002

E 61991

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Lynnewood Hospital

CITY OF BALTIMORE: (No. Liesbon & Huntington Ave. St. 90-69 WARD)

2-FULL NAME Paul palichansky

(a) RESIDENCE NO. 323 S. Smallwood St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
7	6	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stief Palichauski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russian

12 MAIDEN NAME OF MOTHER Daret Fedose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russian

14 Informant Stief Palichauski

(Address) 323 S Smallwood St.

15 Filed NOV 4 - 1930 H. J. Feldmann, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2/30

17 I HEREBY CERTIFY, That I attended deceased from 11/1/30, 19..., to 11/2/30, 19..., that I last saw him alive on 11/2/30, 19 30, and that death occurred, on the date stated above, at 7 45 A m.

The CAUSE OF DEATH* was as follows:

Intussusception of intestines

(duration) ...yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Gangrene of intestines

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 11/1/30

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) W. H. Varner, M. D.

, 19 (Address) Lynnewood Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Russian Independet

DATE OF BURIAL Nov. 4. 19 30

20 UNDERTAKER John Grebliaucka

ADDRESS S PACA St.

Spec.—1-30—M. & T.—250 Bks.

E 61992 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61992

124

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 1-1 WARD)

2-FULL NAME Catherine Volko or Krilko

(a) RESIDENCE NO. 1213 S Ellwood ST. Av WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. * mos. * ds. How long in U. S., if of foreign birth? 21 yrs. * mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Raymont Krilko

6 DATE OF BIRTH (month, day, and year) No. 1892

7 AGE	38	Years *	Months *	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) 0"7

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russian

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russian

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russian

14 Informant Raymont Krilko

(Address) 1213 S Ellwood Ave.

15 Filed 4-1930, 19 W. H. Jones, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2-1930

17 I HEREBY CERTIFY, That I attended deceased from 10-24-30, 19..., to 11-2, 19 30,

that I last saw h[illegible] alive on 11-2, 19 30,

and that death occurred, on the date stated above, at 10 5 (...m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) ...yrs. ...mos 6 ds.

CONTRIBUTORY (Secondary) Acute chloroplasia [redacted]

(duration) ...yrs. ...mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 11-1-30

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Hirst Jr MD M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Russian Independet Cem. DATE OF BURIAL: Nov. 5. 1930

20 UNDERTAKER: John Grebliauckas F.G. ADDRESS: 433 S Paca St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61993

188-203

E 61993

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hosp St. 9-46 Ward)

2-FULL NAME Frederick V. Coxhill

(a) RESIDENCE NO. 1310 Bonaparte Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 20 1913

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	17	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Thos J Coxhill

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Mary Powell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

14 Informant Thos J Coxhill
(Address) 1310 Bonaparte Ave

15 Filed 11-4-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto in which he was riding overturned throwing him out & dragging his body

@ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract. Skull - Rupt Basal Hem. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rockland Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Francis M. D.

11/3 1930 (Address) 2934 Mt Edney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	11/5 1930
20 UNDERTAKER Eugene Tilley	ADDRESS Fulton & Fayette

IF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 61994 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61994

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Penna. Ave ST. 7-24 WARD)

2-FULL NAME Isaac Brown

(a) RESIDENCE NO. 920 Penna Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Isaac Brown

6 DATE OF BIRTH (month, day, and year) 37

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Calvin Thurman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unk —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Isaac Brown (Husband)
(Address) 920 Penna. Ave.

NOV 4 - 1930 WILLIAM H. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to Nov 3, 1930, that I last saw h[illegible] alive on Nov 3, 1930, and that death occurred, on the date stated above, at 6 32 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Hypertension & Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D. Bayless M. D.

11/4, 1930 (Address) 2040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 11-4-1930

20 UNDERTAKER Jack Evans, 1439 E Baltimore St — ADDRESS

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61995

CERTIFICATE OF DEATH.

129 E 61995

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 E. 25th ST., 9th WARD)

2-FULL NAME Mary Lautz

(a) RESIDENCE NO. 1635 E. 25th ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Lautz.

6 DATE OF BIRTH (month, day, and year) Aug. 25 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa.

PARENTS

10 NAME OF FATHER Samuel Leigh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant George E. Lautz (Husband)

(Address) 2106 Gough St

Filed NOV 4 - 1930 HARRY JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2nd 30

17 I HEREBY CERTIFY, That I attended deceased from Aug 28. 1930. to Nov 2. 1930.

that I last saw her alive on Nov 2. 1930.

and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 10 yrs. mos da.

CONTRIBUTORY (Secondary) Coronary Cond

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. E. Lautz M. D.

11-3 1930 (Address) 2858 Harford Rd

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery Hammonds Ferry Rd

DATE OF BURIAL Nov 5 1930

20 UNDERTAKER Lilly & Zeller Inc

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks

E 61996 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61996

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1771 Darley Ave ST., 8 WARD)

2-FULL NAME Kate Muck.

(a) RESIDENCE NO. 1771 Darley Ave ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Muck.

6 DATE OF BIRTH (month, day, and year) Nov 8 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	69	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Tillie Carr Daughter

(Address) 1771 Darley Ave

15 Filed 1930 M. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1st 30

17 I HEREBY CERTIFY, That I attended deceased from April 19 1930 to November 1 1930

that I last saw her alive on November 1 1930

and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
Arterial Hypertension

(duration) 1 yrs. 6 mos da.

CONTRIBUTORY (Secondary) Acute Bronchitis and Cardiac dilatation

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Lewellen M. D.

11/1 1930 (Address) 2025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL Nov. 5 1930

20 UNDERTAKER Lilly & Zeiler Inc

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks

E 61997 HEALTH DEPARTMENT—CITY OF BALTIMORE E 61997

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Edward Tayloy

(a) RESIDENCE NO. 1411 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	widower

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Margaret

6 DATE OF BIRTH (month, day, and year) unknown 1845?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) self 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown Virginia.

PARENTS

10 NAME OF FATHER William Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed ..... H. C. Hudson Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to Nov. 1, 1930, that I last saw him alive on Nov. 1, 1930, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

11-2, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL 11/4/1930

20 UNDERTAKER Samuel H. Hemsley

ADDRESS 578 W. Baltimore

4 AGM

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 61998 90 E 61998

E 61998

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1827 E Fedral ST. 8-17 (WARD)

2—FULL NAME George W Luvall

(a) RESIDENCE NO. 1827 E Federal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	82	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Luvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Mac Farland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Ida B Luvall
(Address) 1827 E Federal st

15 Filed ..... 19.. C. HILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from 10-1, 1930, to 11-3, 1930, that I last saw h.. alive on 11-2, 1930, and that death occurred, on the date stated above, at 7:20 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
(Rheumatic)
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Hilton Jones M. D.

11-3-30 (Address) 820 N Eutaw St M

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Mem

DATE OF BURIAL Nov 5 1930

20 UNDERTAKER Henry Lutz

ADDRESS 1203 Broadway

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 61999

CERTIFICATE OF DEATH.

E 61999

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 105 E. Eutaw St. (Ward) 24-33

2-FULL NAME Catherine A. Pensch

(a) RESIDENCE NO. 105 E. Eutaw ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank J. Pensch

6 DATE OF BIRTH (month, day, and year): Jan. 11-1882

7 AGE — Years: 48 — Months: 9 — Days: 20 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (City or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John E. Weaver

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Caroline Kratz

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto Md.

14 Informant: Frank J. Pensch

(Address): 105 E. Eutaw St.

15 Filed 4-1930

C. HAMPSON JONES, M. D. C. H. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 1. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1930 to Nov. 1, 1930.

that I last saw her alive on Nov. 1, 1930,

and that death occurred, on the date stated above, at 5. A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis, hypertension

(duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 8 hours ds.

18 Where was disease contracted if not at place of death? - - - - -

Did an operation precede death? no Date of - - - - -

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) Henry Weber M. D.

11/3. 1930 (Address) 1224-1226 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Nov 4 1930

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 1422 Light St

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62000

CERTIFICATE OF DEATH

182

E 62000

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Harbor East Falls. ST. 3-3 (WARD)

2-FULL NAME Unknown

(a) RESIDENCE NO. 4 4 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40-?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 667
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 - 1930 C. 92 HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc. Drowning

(duration) ..... yrs. ..... mos. — ds.

CONTRIBUTORY (Secondary) Exposure

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Ex

(Signed) G. Gladden, M. D. Coroner

, 19 (Address) 1-3 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL NOV 3 1930 19

ADDRESS

20 UNDERTAKER

Commissioner Health

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 62001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 62001

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 124 Hesseman Ct St. 22-31 Ward)

2-FULL NAME Louis Jones

(a) RESIDENCE NO. 124 Hesseman Ct. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Jones 1886

6 DATE OF BIRTH (month, day, and year) Not definitely known 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	44	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) around waterfront

(c) Name of employer (?)

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) (?)

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (?)

(State or country)

14 Informant Estella Jones

(Address) 124 Hesseman Ct

15 Filed NOV 4 - 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/1 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1930, to Nov 1, 1930, that I last saw h.~~e~~ alive on Oct 31, 1930, and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH* was as follows:

1 Cerebral Thrombosis

(Left monoplegia)

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of_____

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. H. Carroll, M. D.

11/2, 1930 (Address) 830 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Cemetery Nov 4 1930

20 UNDERTAKER Walter B Griffith ADDRESS 151 Hanover St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 62002

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62002

CERTIFICATE OF DEATH.

31 v

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 531 N. Vincent ST., 14-27 WARD)

2-FULL NAME George Johnson

(a) RESIDENCE NO. 531 N. Vincent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	31	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Julius Boss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Elibeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Bessie Johnson. (Address) 531 N. Vincent St.

15 Filed ..... G. HAMPSON JONES, Registrar. By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 27th, 1930, to October 31, 1930, that I last saw him alive on October 31, 1930, and that death occurred, on the date stated above, at 12.02 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinically

(Signed) Geo. H. Lauenbach M. D.

, 19 (Address) 2215 N. Monroe Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Cemetery DATE OF BURIAL Nov. 4 1930

20 UNDERTAKER Eugene Payne ADDRESS 1721 Edmondson

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61-001

E 62003

CERTIFICATE OF DEATH

E 62003

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1701 Pumphrey ST. 26-37 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Baugher

(a) RESIDENCE. NO 1701 Pumphrey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 1, 1930

7 AGE	Years	Months	Days	If LESS than 1 day 15 hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Ernest S. Baugher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cally Va

12 MAIDEN NAME OF MOTHER Ruby S. Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Petersburg Va.

14 Informant Ernest S. Baugher (Address) 1701 Pumphrey St.

15 Filed . 19 Registrar

NOV 4 - 1930

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 1, 1930, that I last saw him alive on Nov 1, 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

5½ Months

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. W. Keiser, M. D.

11/1, 1930 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Deputy Commissioner of Health.

NOV 5 1930

B. WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-30—M. & T.—250 Bks

Dr. Campbell Hanover St

E 62004

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62004

CERTIFICATE OF DEATH.

129

REGISTERED NO. 24-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1736 Johnson ST. (WARD) 24

2-FULL NAME Lawrence Thomas

(a) RESIDENCE NO. 1736 Johnson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Carrie V. Thomas

6 DATE OF BIRTH (month, day, and year) Feb 6th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltol. Md.

PARENTS

10 NAME OF FATHER Henry Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catine Bruff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Carrie V. Thomas

(Address) 1736 Johnson St

15 Nov 4 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1930, to Nove 3, 1930, that I last saw h/M alive on Nov. 3, 1930, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Indefinite

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. K. Campbell M. D.

11/3, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 11/6/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

NOV 4 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62005

CERTIFICATE OF DEATH

113 E 62005

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2528 Fait Ave ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Regulaski Sr.

(a) RESIDENCE NO. 2528 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 16 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS:

10 NAME OF FATHER Walter Regula

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Lillian Caleb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Walter Regulas

(Address) 2528 Fait Ave.

15 Filed C. HAMPSON JONES, M. D. Registrar

Rec'd

V 4 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1930, to Nov. 2, 1930, that I last saw him alive on Nov. 2, 1930, and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pickets

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. W. Tippey, M. D.

19 (Address) 432 S. Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem

DATE OF BURIAL Nov. 4 1930

20 UNDERTAKER Stephen J. Fiatkowski

ADDRESS 1000 N. Kenwood Ave

IMPORTANT. See instructions on back of certificates. OF DEATH is plainly written

Spec.—1-30—M. & T.—250 Bks.

E 62006 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 62006

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 710 N Monroe ST. 16-27 (WARD)

2-FULL NAME Michael Patrick Hamil

(a) RESIDENCE NO. 710 N Monroe ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White American	married

5a If married, widowed or divorced HUSBAND of ~~or WIFE of~~ Clara O. Hamil

6 DATE OF BIRTH (month, day, and year) Sept 22/1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do County Warden Md Penetentiary - 086

(b) General nature of industry, business, or establishment in which employed (or employer) Md St. Penetentiary

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore city Md

PARENTS

10 NAME OF FATHER Patrick Hamil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland County Corke

12 MAIDEN NAME OF MOTHER Margaret Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Clara O. Hamil (Wife)

(Address) 710 N Monroe St

V 4-1930 File

H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2/30

17 I HEREBY CERTIFY, That I attended deceased from 10/4, 1930, to 11/2/, 1930, that I last saw him alive on 11/2/, 1930, and that death occurred, on the date stated above, at 12.15 Pm.

The CAUSE OF DEATH* was as follows:

Nephritis, arteriosclerosis myocarditis with angina

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C Hampson Jones, M. D.

, 19 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Nov 5th 1930

20 UNDERTAKER George J. Smith

ADDRESS 1532 Hollins St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-30—M. & T.—250 Bks

E 62007

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62007

CERTIFICATE OF DEATH.

100 30 01

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1602 Clifton Ave St. 13-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Lewis

(a) RESIDENCE NO. 1602 Clifton Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary E. Lewis

6 DATE OF BIRTH (month, day, and year) Aug. 9 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER ? Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Mary E. Lewis

(Address) 1602 Clifton Ave.

15 Filed ... 19 ... Registrar

V 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1930. to Nov. 2, 1930.

that I last saw him alive on Nov. 2, 1930.

and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Acute Follicular Tonsillitis

Acute Laryngitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Allen Grossman, M. D.

, 19 (Address) 2340 Gwynn Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Nov. 5 1930

20 UNDERTAKER Wm. J. Pickney & Sons

ADDRESS North & Pa

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 62008

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62008

CERTIFICATE OF DEATH.

90

REGISTERED NO. 1667

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2930 (St.) Baker (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Duvall Wilson

(a) RESIDENCE NO. 2930 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Wilson

6 DATE OF BIRTH (month, day, and year): May 2 1856

7 AGE — Years: 74 — Months: 2 — Days: 1 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home do

(b) General nature of industry, business, or establishment in which employed (or employer): Wood

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland U. S. A.

PARENTS

10 NAME OF FATHER: Elias B Magruder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md U. S. A.

12 MAIDEN NAME OF MOTHER: Rosanna Crodley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md U. S. A.

14 Informant: Louis Kunard

(Address) 2930 Baker

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1930, to Nov 2, 1930, that I last saw h[er] alive on Nov 1- 1930, and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ... yrs. ... mos. Sudden ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M Baumanstead M. D.

Nov 3 1930 (Address) 2216 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Nov 5 1930

20 UNDERTAKER: H. Plummer Sons — ADDRESS: North Ave

CAUSE OF DEATH in plain terms. Abbreviations not allowed. TION is very important. See instructions on back of certificates.

V 4-1930

Spec. 2-29-28—L. F. S.—500 Blks.

E 62009

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62009

CERTIFICATE OF DEATH

REGISTERED NO. 452

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3114 E Baltimore St. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine Anna Zuellinger

(a) RESIDENCE NO. 3114 E Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Andrew Zuellinger

6 DATE OF BIRTH (month, day, and year) March 23-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Cath Ostendorf.

(Address) 265 Forrest Ave

15 Filed NOV 4 1930, 19..., G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3-1930

17 I HEREBY CERTIFY, That I attended deceased from March 1 1930, to Nov 3 1930

that I last saw h alive on Nov 2 1930

and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

Arterio-Sclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Toxic Absorption

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Brook, M. D.

11/3, 1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Mem

DATE OF BURIAL Nov 6th 1930

20 UNDERTAKER Leo J Brook

ADDRESS 1723 Patt Pk Ave

NOV 4 1930

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 62010

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62010

CERTIFICATE OF DEATH.

1-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 17-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Doyle

(a) RESIDENCE NO. 429 E. Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	white	—

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb- 14/30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	2wks	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Celia Madeleen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address)

Filed 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from 10-24, 1930, to 11-3, 1930, that I last saw him alive on 11-3, 1930, and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab

(Signed) J. Doyle, M. D.

11/3, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Nov. 5, 1930

20 UNDERTAKER Curley & Co. Inc.

ADDRESS 1221 N. Eutaw

V 4-1930

CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—1-30—M. & T.—250 Bks.

E 62011

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62011

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. North Broadway ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME McIlhenny, Alverder

(a) RESIDENCE NO. 1110 Entan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9th 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74 / 73		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher, retired

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James M McIlhenny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Elverder Browning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Rhoda M. Green

(Address) 1100 Guilford Ave

15 Filed NOV 4 - 1930 C. HAMPSON JONES, M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3d, 1930.

17 I HEREBY CERTIFY, That I attended deceased from October 28th, 1930, to November 3, 1930, that I last saw her alive on November 3d, 1930, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral stenosis and insufficiency

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No confirmation any special test.

(Signed) C E Hubbard, M. D.

11/3, 1930 (Address) 409 Cornwall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Nov 6 1930

20 UNDERTAKER Henry Jenkins Sons Co

ADDRESS Orchard & McCulloh Sts

CAUSE OF DEATH to be plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-30—M. & T.—250 Bks.

E 62012 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62012

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lydenham Hospital ST., 29-45 WARD)

2-FULL NAME John Rick

(a) RESIDENCE NO. S.S. Barbara, Balt. Line WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 15, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	24	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamship Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Steamship Owners

(c) Name of employer Bull Line

9 BIRTHPLACE (city or town) Janesville (State or country) Wisconsin

PARENTS

10 NAME OF FATHER James Rick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Frances Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. James Rick

(Address) Cabo, Fla. Box 66

15 4 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1930, to Nov. 4, 1930, that I last saw him alive on Nov. 4, 1930, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiovascular Renal Disease with myocardial failure

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Leprosy

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Nasal cultures

(Signed) L. P. Weranecki, M. D.

, 19 (Address) Lydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tarrytown, N. Y. DATE OF BURIAL Nov. 5 1930

20 UNDERTAKER Wm J. Tickner & Son ADDRESS North Ave.

CAUSE OF DEATH. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62013

CERTIFICATE OF DEATH

129 ✓

E 62013

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3006 Baker ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.) 16-67 WARD)

2—FULL NAME Fillie Amelia Breyer

(a) RESIDENCE NO. 3006 Baker ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md

PARENTS

10 NAME OF FATHER Louis Breyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Schlegel Ernestine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank F Breyer

(Address) 3006 Baker St

15 Filed ..., 19... [illegible] JAMES H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1930, to Nov. 4, 1930

that I last saw her alive on Nov. 4, 1930

and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia. Cerebral Apoplexy (duration) 8 yrs. 8 mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis, phys. exam.

(Signed) Bartus I. Baggett M. D.

19 (Address) 2229 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Nov 6 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 62014

E 62014

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Convent of Notre Dame WARD) 12-14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sr. M. Cecilia Tehaga

(a) RESIDENCE NO. 90 Ansonia ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1854

7 AGE 75	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jos. Tehaga

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Wachs

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sister of Mother Superior

(Address) Convent of N.D. Ansonia & Pol

15 Filed NOV 4 - 1930 H. L. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to November 3, 1930, that I last saw h. alive on November 3, 1930 and that death occurred, on the date stated above, at 1.40 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Exhaustion (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) J. J. Kirby, M. D.

Nov 4, 1930 (Address) 1106 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loch Cliff Md

DATE OF BURIAL Nov 5 1930

20 UNDERTAKER Frank A. Fink

ADDRESS 916 N. Gay St.

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

24 1983

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 E 62015

CERTIFICATE OF DEATH. × 100-001

E 62015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Horace Hatcher

(a) RESIDENCE NO. Jenkins Ky ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec 3-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ky

PARENTS

10 NAME OF FATHER James Hatcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Herford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

Filed NOV 4 - 1930 C. H. Parran JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-4-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Nov 4, 1930, that I last saw him alive on Nov 4, 1930, and that death occurred, on the date stated above, at 1 55 A m.

The CAUSE OF DEATH* was as follows:

Non specific ulceration colitis

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Tennessee

Did an operation precede death? yes Date of 10-24-30

Was there an autopsy? yes

What test confirmed diagnosis? Post mortem

(Signed) E H Campbell Jr, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bristol va Dem

DATE OF BURIAL 11/4/30

UNDERTAKER B. Joseph Abrams

ADDRESS 224 Bway

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-30—M. & T.—250 Bks.

249159 Neuro Surg E 62016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 154 E 62016

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Risk

(a) RESIDENCE NO. Brown City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. N. Car. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	—

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Laura Boon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Parents (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 4 1930, 19 H. J. POPE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-4-30

17 I HEREBY CERTIFY, That I attended deceased from 10-27-, 1930, to 11-4-, 1930, that I last saw h[illegible] alive on 11-4-, 1930, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus communicating type

(duration) yrs. 2 mos 7 ds.

CONTRIBUTORY (Secondary) Hemorrhage from operation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-4-30

Was there an autopsy? yes

What test confirmed diagnosis? P. M.

(Signed) Fred W Suit, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tryon City N. C.

DATE OF BURIAL Nov 6th 1930

20 UNDERTAKER Chas H Evans & Son

ADDRESS 118 W Mt Royal Ave.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

V 4 1930

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62017

CERTIFICATE OF DEATH.

113 E 62017

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Mayer

(a) RESIDENCE NO. 2002 E Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	—

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 22 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Albert Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Gertrude Engelhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hospital Records

(Address)

15 Filed 5-1930, 19 . H. M. CARLTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from 10-31, 1930, to 11-3, 1930,

that I last saw h[illegible] alive on 11-3, 1930,

and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Fermentative diarrhea

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Zeyro, M. D.

11/3, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov. 5 1930

20 UNDERTAKER John H. Valentine — ADDRESS 2326 Aiken St.

INSTRUCTION is very important See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 62018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Crauf.

E 62018

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1137 Fshburton St. 16-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm F. Brauf

(a) RESIDENCE NO 1137 Fshburton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie W.

6 DATE OF BIRTH (month, day, and year) July 19-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Collector
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Fred W. Brauf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Shafer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank W. Petel

(Address) 2820 Laureus St

15 Filed NOV 5 - 1930, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician.

(Signed) H. Schuck, M. D. Coroner

(Address) 1017

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Nov 5 1930

20 UNDERTAKER Thanowitz Son

ADDRESS 3615 Elliott

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificate.

NOV 5-1930

SENOF NO. 3 NORTH

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62019

CERTIFICATE OF DEATH.

100-001

E 62019

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2825 W Lanvale ST. 16-68 WARD)

2-FULL NAME Mary Linthicum Craig

(a) RESIDENCE NO. 2825 W. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 74 yrs. 10 mos. 17 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Robt. M. Craig

6 DATE OF BIRTH (month, day, and year): Dec 17 1855

7 AGE: Years 74 | Months 10 | Days 17 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: J. Solon Linthicum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. Md.

12 MAIDEN NAME OF MOTHER: Sarah C. Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Md.

14 Informant: Mrs D.M. Reese Sister

(Address) 101-W-Monument St

15 Filed NOV 5 - 1930 H. SYLVESTER JONES, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1930, to Nov 3, 1930,

that I last saw h[illegible] alive on Nov 2, 1930,

and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Chronic Arthritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Duvall M. D.

Nov 3, 1930 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Nov 5 1930

20 UNDERTAKER: Stewart & Co

ADDRESS: Balto.

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62020

E 62020

CERTIFICATE OF DEATH.

91-02

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Valley St. 10-14 WARD)

2-FULL NAME Thos Hayden

(a) RESIDENCE NO. 1217 Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Hayden

6 DATE OF BIRTH (month, day, and year) Dec 5 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co., Md

PARENTS

10 NAME OF FATHER Thos. Hayden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire

14 Informant Annie Hayden

(Address) 1217 Valley St

15 Filed NOV 5 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3/30

17 I HEREBY CERTIFY, That I attended deceased from 7/26, 1930, to 11/3, 1930, that I last saw h alive on 11/2, 1930, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wise M. D.

11/4, 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Nov. 6 1930

20 UNDERTAKER Rita Wiedefeld

ADDRESS 114 Fremont Ave

CAUSE OF DEATH TION is very important See instructions on back of certificate.

E. JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

Hagenbuch

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62021 ✓ E 62021

CERTIFICATE OF DEATH

REGISTERED NO. 15-63

1—PLACE OF DEATH Franklin Square Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2—FULL NAME Mary Hagenbuch

(a) RESIDENCE NO. 3816 Belle Ave. ST., ... WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Md

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Edward Hagenbuch

6 DATE OF BIRTH (month, day, and year) May 25 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Victoria British Columbia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Edna M Hagenbuch

(Address) 3816 Belle Ave

15 Filed NOV 5 1930 H. WILSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2-30

17 I HEREBY CERTIFY, That I attended deceased from 10-31, 1930, to 11-2, 1930, that I last saw him alive on 11-2-30, 1930, and that death occurred, on the date stated above, at 6 20 A. m.

The CAUSE OF DEATH* was as follows: Perforated appendicitis

(duration) ... yrs. ... mos. 4d. ds.

CONTRIBUTORY (Secondary) General peritonitis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-31-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) C. H. Peake, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Nat'l

DATE OF BURIAL: Nov 5 1930

20 UNDERTAKER: W M Routson

ADDRESS 2235 W North

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

Pasquale D'Antonio

E 62022

62022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 84

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Hospital. ST. 21-24 WARD)

2-FULL NAME Patsy D'Antonio

(a) RESIDENCE NO. 1349 Glyndon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Josephine D'Antonio

6 DATE OF BIRTH (month, day, and year) Aug 18 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio D'Antonio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carolina (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Record (Address)

15 Filed NOV 5 1930 H. LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-4-30

17 I HEREBY CERTIFY, That I attended deceased from 10-28, 1930, to 11-4, 1930, that I last saw h alive on 11-4, 1930, and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Probable Brain Tumor

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Geyer M. D.

11/4, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Nov 7 1930

20 UNDERTAKER W. M. Preston

ADDRESS 2238 W. Balto

TION is very important. See instructions on back

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62023

CERTIFICATE OF DEATH.

E 62023

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 607 W Franklin ST. 17-25 WARD)

2-FULL NAME Isabella H Carter

(a) RESIDENCE NO. 607 W Franklin ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... How long in U. S., if of foreign birth? ... yrs. ... mos. ...

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widd

Sa ~~Married~~ widowed, or ~~divorced~~

(or) WIFE of E. J Carter

6 DATE OF BIRTH (month, day, and year) 12/5/1856

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min
74	1856	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER J. J. Betts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Isabella Harding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant R B Kenyon

(Address) 607 W Franklin

15 Filed ... 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-29, 1930, to Nov 4, 1930, that I last saw her alive on Nov 4, 1930 and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 0 yrs. 0 mos 6 ds.

CONTRIBUTORY (Secondary) Pressure on brain

Cerebris (duration) 0 yrs. 0 mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) R B Kenyon, M. D.

, 19 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Va Moratico County

DATE OF BURIAL Nov 6 1930

20 UNDERTAKER W M Knotts

ADDRESS 223 N Arlington

CAUSE OF DEATH ... See instructions on back of certificate. TION is very important.

E 62023

Spec.—1-10-21—M&T—1500 Bks.

E 62024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69 E 62024

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 777 N. Mulberry St., (WARD) 4-16

2-FULL NAME Clyborn Mingo

(a) RESIDENCE No. 777 N. Mulberry St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 30, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Clyborn Mingo

11 BIRTHPLACE OF FATHER (city or town) Lancaster
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Edith

13 BIRTHPLACE OF MOTHER (city or town) Great Falls
(State or country) S. C.

14 Informant Clyborn Mingo
(Address) 777 N. Mulberry St.

15 Filed ..... 19.. C. HAMPTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 30 1930 to Nov 2 1930.

that I last saw him alive on Nov 2 1930,

and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Neoplasm Neonatorum
(Morbus Maculosus Neonatorum)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Leo. H. Lowenburg M. D.

11-3 1930 (Address) 225 St. Paul Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Hope Cemetery

DATE OF BURIAL: Nov 5, 1930

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 E Schroeder St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important

61 - 5 AON

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62025

CERTIFICATE OF DEATH

31 V E 62025

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4801 Morella Road ST., 27-41 WARD)

2—FULL NAME W. Evelyn Wehner

(a) RESIDENCE NO. 4801 Morella Rd. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 7 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Co.

PARENTS

10 NAME OF FATHER George C. Wehner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Christina Homberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Christina Homberg
(Address) 4801 Morella Road

15 Filed NOV 5 - 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3/1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1928, to Nov 3, 1930, that I last saw him alive on Nov 2, 1930, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? .....

(Signed) W. S. Gamm, M. D.

19 30 (Address) 677 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Nov 6 1930

20 UNDERTAKER: for J. B. Stevenson — ADDRESS: 156 Eugene Ave

Important. See instructions on reverse side.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

62026

CERTIFICATE OF DEATH

11-27-53 185 V

REGISTERED NO. E 62026

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2809 Goodwood Road ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Theresa Herr

(a) RESIDENCE NO 2809 Goodwood Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28/ 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	0	6 5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Michael Herr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Kesler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Fick

(Address) 2809 Goodwood Road

15 Filed NOV 5 - 1930 C. HAMILTON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Skull - Accidently fell from 2nd story window at residence while cleaning window.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D. Coroner

Nov , 19 (Address) 508nE. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Gen 6 30

DATE OF BURIAL 19

20 UNDERTAKER [illegible]

ADDRESS 132 Lafayette

CAUSE OF DEATH in plain words. See instructions on back of certificate. TION is very important.

Spec.—1-30—M. & T.—250 Bks.

E 62027

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62027

CERTIFICATE OF DEATH.

129

REGISTERED NO. 26-41

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Berkshire Ave. ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John Gunkel

(a) RESIDENCE NO. 3107 Berkshire Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Augusta H. Gunkel

6. DATE OF BIRTH (month, day, and year) February 5, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper, retired

(b) General nature of industry, business, or establishment in which employed (or employer) Groceries

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Gunkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Schaeffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Augusta H. Gunkel 3107 Berkshire Ave.

15 Filed NOV 5 - 1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1930.

17 I HEREBY CERTIFY, That I attended deceased from March, 1930, to Nov 3, 1930; that I last saw him alive on Nov 3, 1930; and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis 8 mos. (Chronic)

Cardio-vascular-renal — 10 yrs —

CONTRIBUTORY (Secondary) Arterial Hypertension — 10 yrs —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy. exam —

(Signed) Louis F. Krumbein, M. D.

19 (Address) 722 N. Kenwood Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 11/5/30

ADDRESS 2008 Orleans St

20 UNDERTAKER John Ulrich

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62028

E 62028

CERTIFICATE OF DEATH.

REGISTERED NO. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2808 Harlem Ave St. 46-68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Reger

(a) RESIDENCE No. 2808 Harlem Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria Germany

PARENTS

10 NAME OF FATHER John A Reger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Frank A Reger Son 30 Poplar Grove St

15 Filed Nov 4 1930 JOHN JONES, M. D. Registrar

NOV 5 - 1930.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st 1930, to Nov 4th 1930.

that I last saw h[illegible] alive on Nov 3rd 1930.

and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Senile Decay (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F Mortimer M. D.

(Address) 2307 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Nov 6 1930

20 UNDERTAKER: Mary A Gauthrop ADDRESS 2839 Rayner Ave

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec. 1-30 M. & T.—250 Bks.

E 62029

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62029

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1009 N. Bond ST., 7-13 (WARD)

2-FULL NAME Herman J. Wunderlich

(a) RESIDENCE NO. 1009 N. Bond ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of ~~(or) Wife of~~ Marie C. Wunderlich

6 DATE OF BIRTH (month, day, and year) Oct 27th 1864

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail Baker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Nicholaus Wunderlich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Joseph L. Wunderlich 3013 Kenyon Ave.

15 Filed NOV 5 - 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 3. 30.

17 I HEREBY CERTIFY, That I attended deceased from October 29, 30 to November 3, 19 30.

that I last saw h~~im~~ alive on November 2, 19 30, and that death occurred, on the date stated above, at 6-15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What confirmed diagnosis? Clinical

11 (Signed) Hilles H. A. Meyer M. D.

3, 19 30 (Address) 1034 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov 6th 19 30

ADDRESS

20 UNDERTAKER George Schilling & Sons

1126 E Monument St

TION is very important

Spec.—1-30—M. & T.—250 Bks.

E 62030

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62030

CERTIFICATE OF DEATH.

REGISTERED NO. 1610 E 62030

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital ST. 18-29 WARD)

2-FULL NAME Richard Hoggard.

(a) RESIDENCE NO. 1134 West Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 18 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct 16th 1930

7 AGE	Years	Months	Days 15	If LESS than 1 day, ...hrs. or ....min.
~~15 days~~	✓	✓	18	

8 OCCUPATION OF DECEASED ✓

(a) Trade, profession or particular kind of work ✓ Bro

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Willoughby Hoggard

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Amelia Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaplate

14 Informant Hospital Records.

(Address)

15 Filed 5-1930, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 28th, 1930, to Nov 1st, 1930,

that I last saw him alive on Nov 1st, 1930,

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ✓ yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy?

What test confirmed diagnosis? Clinical History

(Signed) J. S. Fiske M.D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Body preserved for autopsy at use of training school by permission of Dr Carl Davis & J S Fiske M.D. 19

20 UNDERTAKER ADDRESS

TION is very important. Be sure

Spec.—1-30—M. & T.—250 Blks.

Thorpe.

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001

62031

CERTIFICATE OF DEATH.

E 62031

REGISTERED NO.

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division ST. 2231 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy Gordon Thorpe

(a) RESIDENCE NO. 160 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year)			
7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8 mo.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Crawford Thorpe

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Florence Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Florence Thorpe

(Address) 160 Hamburg St

Filed 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/20, 1930, to 11/2, 1930, that I last saw him alive on 11/2, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis (non specific)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Otitis media. (duration) Unknown ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) George McDonald M.D.

, 19 (Address) 900 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct

DATE OF BURIAL 11/5/30 19

ADDRESS 108 W Monday

UNDERTAKER Isaiah L Brown

TION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62032 | 179 E 62032 REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1015 Hanover ST., WARD) 23-31

2—FULL NAME Margaret Kenny

(a) RESIDENCE NO. 1015 Hanover ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Frederick Kenny

6 DATE OF BIRTH (month, day, and year) Oct 6 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	0	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) London England

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cahill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary A. Burns Daughter

(Address) 1015 Hanover

15 Filed NOV 5 - 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3-1930

17 I HEREBY CERTIFY, That I attended deceased (from Sept. 27, 19 30, to Nov 3, 19 30, that I last saw h[er] alive on Nov 2, 19 30 and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

1 Hypertension Chronic Interstitial Nephritis
Uraemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Symp.

(Signed) Thos. Fa Stearns, M. D.

11/4, 19 30 (Address) 2578 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Nov. 7 1930

20 UNDERTAKER J. A. Hannon Son — ADDRESS 783 Hanover

Spec.—1-12-23—M&T—500 Blks.

E 62033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 62033

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Aiken St. ST. 23-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Rheinheimer

(a) RESIDENCE NO. 9 E. Ostend St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5.1.1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Sarah Gardner

(Address) State Sanatorium Md.

15 Filed NOV 4 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11.3.30. 19

17 I HEREBY CERTIFY, That I attended deceased from 10.27.30. , 19 , to 11.3.30. , 19 , that I last saw h@alive on 11.3.30. , 19 , and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma.

(duration) — yrs. — mos 14 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? 9 E. Ostend St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical chemical

(Signed) Otto B. Fowler, M. D.

11.4.1930. (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newfield N J

DATE OF BURIAL Nov 5 1930

20 UNDERTAKER Fred a Kennedy

ADDRESS 703 Hamilton Ave

1-30—M. & T.—100 B—50L

Henry A. Domm

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 ✓ E 62034

62034

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 20-69 WARD)

2-FULL NAME Henry A. Domm

(a) RESIDENCE NO 2667 St. Benedict ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of Elizabeth Domm
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 4/1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nightwatchman
(b) General nature of industry, business, or establishment in which employed (or employer) 062
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Elizabeth Domm
(Address) 2667 St. Benedict St

15 Filed Nov 2 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Septicemia Obstruction of bowel

Probably Cancer of Sigmoid

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.

, 19 (Address) 1 W. Cold Spring Lane, North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mathews Cemetery

DATE OF BURIAL Nov 6 1930

20 UNDERTAKER Fred A. Krauseker

ADDRESS 703 Hamilton

TION is very important See instructions on back of certificate

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

62035

CERTIFICATE OF DEATH.

118-002

REGISTERED No. E 62035

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Roulard & Grove ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walsh

(a) RESIDENCE NO. 1224 Sargeant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Norfolk Walsh

6 DATE OF BIRTH (month, day, and year) July 10 1878

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009 Plumbing Supplies

(b) General nature of industry, business, or establishment in which employed (or employer) James Robinson

(c) Name of employer The Co. Company Baltimore

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John R. Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Flora

13 BIRTHPLACE OF MOTHER (city or town) Balto Co. (State or country) Md

14 Informant Elizabeth Norfolk Walsh

(Address) 1224 Sargeant Street

15 Filed HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 4, 1930, that I last saw h alive on Nov. 4, 1930, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) — yrs. — mos. 4 da.

CONTRIBUTORY (Secondary) Toxemia (duration) — yrs. — mos. 4 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 3

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) G. J. Brady, Jr., M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 11/7/1930

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

24855
E 62036

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62036

CERTIFICATE OF DEATH.

16-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Steve Regas

(a) RESIDENCE No Back River and Towson Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6-1930

7 AGE: Years —; Months 3; Days 27; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Steve Regas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Jennie Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 5-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-3-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-20, 1930, to Nov 3, 1930, that I last saw him alive on Nov 3, 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Enteritis

Dysentery, bacillary

(duration) yrs. mos 15 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

11/4, 1930 Address) 4 H. Loop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL November 6th 1930

20 UNDERTAKER George A. Weber ADDRESS 705 Lamon st.

Spec.—1-30—M. & T.—250 Bks

E 62037

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62037

16-002

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Municipality Hospital

CITY OF BALTIMORE: (No. Lombard & Green St. 4-76 WARD)

2-FULL NAME Harry Love

(a) RESIDENCE NO. 723 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Love

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Margaret Parkson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Thomas Love
(Address) 723 W. Lexington St.

15 Filed NOV 5 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1930, to Nov. 3, 1930, that I last saw h... alive on Nov. 3 1930, and that death occurred, on the date stated above, at 9:40 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) ... yrs. ... mos 7 ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) ... M. D.

19 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 11/5/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62038

CERTIFICATE OF DEATH

135

E 62038

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2431 Maryland Ave ST., 47-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph K. Benson

(a) RESIDENCE NO. 2431 Maryland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (~~write the word~~): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Elizabeth Benson

6 DATE OF BIRTH (month, day, and year): Mar 7-1844

7 AGE: Years 86 | Months 7 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 986

(b) General nature of industry, business, or establishment in which employed (or employer): Commission

(c) Name of employer: A. & Co

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country): A & Co Md

12 MAIDEN NAME OF MOTHER: Mary E. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Geo. M. Benson

(Address) 2431 Maryland Ave

15 Filed NOV 5 1930, 19... E. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 19.30, to November 4, 19.30, that I last saw h. alive on November 3 1930, 19 30 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Hypertrophied prostate, urinary obstruction

(duration) Some yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritic Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about Oct 5. 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George M. Settle M. D.

11/4, 1930 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lot Benson Family Burying

DATE OF BURIAL: Nov 6 1930

20 UNDERTAKER: Bertrand

ADDRESS: 1723 W Lafayette Ave

Spec.—1-30—M. & T.—250 Bks.

E 62039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62039

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 13-59 (WARD)

2-FULL NAME Sanders Thalheimer

(a) RESIDENCE NO. 2414 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Mary V. Thalheimer

6 DATE OF BIRTH (month, day, and year) Dec 23 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Sanders Thalheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Rentmeister

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Sanders Thalheimer 2414 Eutaw Place

15 Filed NOV 5 - 1930 H. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1930, to Nov. 4, 1930, that I last saw h[illegible] alive on Nov 4, 1930, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Uremia Neoplasm

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pyelonephritis (Bilateral) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical findings

(Signed) M. Cohen, M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cemetery DATE OF BURIAL Nov 6 1930

ADDRESS

20 UNDERTAKER J. Ahearn & Co 2430 Pennsylvania Ave

pec.—1-30—M. & T.—250 Bks.

23347

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-003

23 E 62040

CERTIFICATE OF DEATH.

E 62040

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Chase

(a) RESIDENCE NO. 1617 Presbury St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months: 4 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —— old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Tuckmann

11 BIRTHPLACE OF FATHER (city or town) Tuckmann (State or country)

12 MAIDEN NAME OF MOTHER Silbein

13 BIRTHPLACE OF MOTHER (city or town) Tuckmann (State or country)

14 Informant Friends -

(Address)

15 Filed NOV 5 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27-30

17 I HEREBY CERTIFY, That I attended deceased from June 25 - 1930 to Oct - 27 1930, that I last saw him alive on Oct - 27 1930, and that death occurred, on the date stated above, at 10 15a - m.

The CAUSE OF DEATH* was as follows:

Cardiac failure due to Cardiac anomaly.

(duration) yrs. 4 mos da.

CONTRIBUTORY (Secondary) Imperforate anus & recto vesical fistula (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? V Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) [illegible] M. D.

11/2 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: NOV 5 1930 19

ADDRESS

UNDERTAKER

Commissioner Health

JOHNS HOPKINS HOSPITAL

Spec.—1-30—M. & T.—250 Bks.

62041

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 E 62041

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 18-No WARD)

2-FULL NAME Walter Price

(a) RESIDENCE NO. 108 No. Schroeder ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Morris Price

11 BIRTHPLACE OF FATHER (city or town) Bishopville
(State or country) So. Carolina

12 MAIDEN NAME OF MOTHER Ola James

13 BIRTHPLACE OF MOTHER (city or town) Darlington
(State or country) So. Carolina

14 Informant Ola Price
(Address) 108 No Schroeder St

15 Filed 31-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3/30.

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov 3, 1930,
that I last saw him alive on Nov. 3, 1930,
and that death occurred, on the date stated above, at 2 05 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) 0 yrs. 0 mos 15 ds.

CONTRIBUTORY (Secondary) Tuberculous Enteritis
(duration) 0 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? 108 No Schroeder St

Did an operation precede death? no Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. Peter Meyerhoff, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	NOV 5 1930
20 UNDERTAKER Comm'r Health	ADDRESS

pec.—1-30—M. & T.—250 Bks.

0472576
E 62042

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62042

CERTIFICATE OF DEATH.

+113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Tharpe

(a) RESIDENCE NO. German Hill Rd ST., Highlandtown WARD Balto. County, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	—

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9/25/30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	5 wks. 1 d.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Pennie Tharpe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va —

12 MAIDEN NAME OF MOTHER Ethel Cantani

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Records — (Address) JOHNS HOPKINS HOSPITAL

Filed NOV 5 - 1930 BALTIMORE, MD. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-3-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 3, 1930, that I last saw him alive on Nov 3, 1930, and that death occurred, on the date stated above, at 240 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Dist. Enteritis and diarrhoea (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Campbell Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL NOV 5 1930

ADDRESS

20 UNDERTAKER Commissioner Health

For Wm. H. WOOLLEY

pec.—1-30—M. & T.—250 Bks.

E 62043 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 62043

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Provident Hosp.

CITY OF BALTIMORE: (No. 1514 Division ST. 1627 WARD)

2-FULL NAME William Howard

(a) RESIDENCE NO. 621 N. Mount St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 12-1929

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	1 yr.	6 mo.	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Edith Howard
(Address) 1617 Frankingwood Ave

Filed 5-1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3rd, 1930., to Nov. 4th, 1930.,
that I last saw him alive on Nov. 4th, 1930.,
and that death occurred, on the date stated above, at 7 55 p m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Mrs. Brown's

Did an operation precede death? No Date of .....

Was there an autopsy? ~~Yes~~ No

What test confirmed diagnosis? Clinical ~~& Autopsy~~

(Signed) Dr. George Mc Donald, M. D.

11/4 1930 (Address) 900 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 11/7/1930

20 UNDERTAKER Joseph A. Lively Mrs. Lillie E. Lively ADDRESS 1400 Druid Hill Ave

1-30—M. & T.—100 B—50L

E 62044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62044

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST., 17-25 WARD) 160

2-FULL NAME Alexandria Jones

(a) RESIDENCE NO 406 Diamond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of NV.

6 DATE OF BIRTH (month, day, and year) Oct 19-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Louise Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Louise Jones

(Address) 406 Diamond

15 Filed NOV 5 - 1930 H. HAMROCK JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Hamrock Jones, M. D. Coroner

Nov 5 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 11/5/1930

20 UNDERTAKER Mrs. Leo. A. Kreland

ADDRESS 1601 Druid Hill Ave

TION is very important. See instructions on

Dec.—1-30—M. & T.—250 Bks.

Scriba ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62045

31 E 62045

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2122 N. Balto. ST. 70-69 WARD)

2-FULL NAME Henry D. Scriba

(a) RESIDENCE No. 2122 N. Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Geneva B. Doud

6 DATE OF BIRTH (month, day, and year): June 30 or 1889

7 AGE — Years: 41 — Months: 4 — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Julius F. Scriba

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eleanor R. Douglass

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Baltimore Md

14 Informant: Mamie R. Douglass

(Address) 2122 N. Baltimore St.

Filed DEC 5 - 1930, 19.. H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1930, to Nov 3rd 1930, that I last saw h... alive on Nov 3rd 1930, and that death occurred, on the date stated above, at 12 20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sputum & Physician

(Signed) Chas A Carter M. D.

(Address) 2145 N Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY — DATE OF BURIAL: Dec 5th 1930

UNDERTAKER: E. B. Hofgard — ADDRESS: 1850 N Balto St

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 161-001

52046

REGISTERED NO. 52046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1215 (ST.) Durst (WARD) 24-23 E

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Francis Calvert

(a) RESIDENCE NO. 1215 Durst ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Calvert

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ethel Thomas

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto. Md.

14 Informant Mrs. Ethel Calvert

(Address) 1215 Durst St.

Filed NOV 5 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1930, to Nov. 4, 1930, that I last saw him alive on Nov. 4, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Premature Birth
7 months
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. L. Campbell M. D.

11/5, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Nov. 5, 1930

20 UNDERTAKER Charles Ogley & Co. Inc.

ADDRESS 1021 W. Fayette St.

TION is very important. See instructions on back

pec.—1-30—M. & T.—250 Bks

2047

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62047

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3500 Foster ST., (16-37 WARD)

2-FULL NAME Sister Burchardas (Anna Weckerle)

(a) RESIDENCE NO. 3500 Foster ave ST., 26 WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 31st 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y. City

PARENTS

10 NAME OF FATHER George Weckerle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alsace Lorraine

12 MAIDEN NAME OF MOTHER Mary E. Schmitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Mary Weckerle
(Address) 414 E. Little St. N.Y. City

15 Filed NOV 5 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4th 30

17 I HEREBY CERTIFY, That I attended deceased from 11/3, 19 30, to 11/4, 19 30, that I last saw her alive on 11/4/30, 19, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Tonsulitis, chronic
Myocarditis

(duration) 1 yrs. — mos — da.

CONTRIBUTORY (Secondary) Acute Coronary Occlusion

(duration) — yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Farrell M. D.

11/4, 1930 (Address) 633-5 Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Cliff Cem.

DATE OF BURIAL Nov. 6 1930

20 UNDERTAKER Lilly Zeller inc

ADDRESS 403 S. Wolfe St

Dec.—1-30—M. & T.—250 Bks

E 62048

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62048

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals 27-31 WARD)

CITY OF BALTIMORE: (NO. ST.,

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lane

(a) RESIDENCE NO. 127 W. Montgomery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

3a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER John ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Prissie Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

Filed 11-5-30 Ruth Jones, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from 7-25-30, 19 , to 11-3-30, 19 ,

that I last saw him alive on 11-3-30, 19 ,

and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

More than 1½ yrs. mos ds.
(duration)

CONTRIBUTORY (Secondary) Gangrene of leg, diabetic (duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 1-31-30

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy, Lab.

(Signed) Paul Padget, M. D.

11-5, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL Nov 5 1930

ADDRESS

UNDERTAKER S. Joseph A Lurly 409 Mumford St

Dec.—1-30—M. & T.—250 Bks.

E 62049 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62049

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Sinai Hosp

CITY OF BALTIMORE: (NO. ..... ST. 413 E. Clinton (WARD) .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary O'Connor

(a) RESIDENCE NO. 413 E. Clinton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 55 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Thomas O'Connor

6 DATE OF BIRTH (month, day, and year): 5/1/867

7 AGE: Years 63 | Months 6 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Moone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: John O'Connor

(Address): 413 E. Clinton St

15 Filed ..... 19 ..... C. MILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 4, 1930

that I last saw h[illegible] alive on Nov 4, 1930

and that death occurred, on the date stated above, at 3 AM m.

The CAUSE OF DEATH* was as follows:

Chr pulmonary emphysema

Arteriosclerosis

Chr. myocarditis

(duration) 20 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Morton Blum, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery

DATE OF BURIAL: 11/6/30

20 UNDERTAKER: George J. Patty Sons

ADDRESS: 1230 Hanover

Sec.—1-30—M. & T.—250 Bks.

72133

42E 45

HEALTH DEPARTMENT—CITY OF BALTIMORE

42E 62052

16-002E 62050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 425 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Geppi

(a) RESIDENCE NO. 677 W-Fayette ST., 88 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/1/30

7 AGE: Years — Months 3½ — Days 14 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Frank Geppi

11 BIRTHPLACE OF FATHER (city or town) Md —
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Gutman

13 BIRTHPLACE OF MOTHER (city or town) Md —
(State or country)

14 Informant Friends —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930, to Nov. 3, 1930, that I last saw him alive on Nov. 3, 1930, and that death occurred, on the date stated above, at 3 10 p m.

The CAUSE OF DEATH* was as follows:

Dysentery, bacillary

(duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. C. Godwin, M. D.

11/3, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 11/10/30

20 UNDERTAKER Geo. E. Pugh & Son

ADDRESS 1735 Hoff Ave

Dec.—1-30—M. & T.—250 Bks.

62051 E 62051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4-25 ST., WARD)

2-FULL NAME Elizabeth Tyson

(a) RESIDENCE NO. 645 W Fayette ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Wm. Tyson

6 DATE OF BIRTH (month, day, and year): Aug 27, 1870

7 AGE: Years 60; Months 2; Days 5; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: ? Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ?
(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: David Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Ireland

12 MAIDEN NAME OF MOTHER: Margaret Crowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Ireland

14 Informant: Friends (Address): Baltimore City Hosp.

Filed 5-1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-2-30

17 I HEREBY CERTIFY, That I attended deceased from 7-16-, 1930, to 11-2-, 1930, that I last saw alive on 11-2-, 1930, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Varicose Ulcers of Legs

(duration) unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Sym.

(Signed) Fred M. Duckwall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — DATE OF BURIAL: 11/5 1930

20 UNDERTAKER: John J. Fisher & Sons — ADDRESS: 131 Eight St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62052

CERTIFICATE OF DEATH.

138 E 62052

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 2000 WARD)

2-FULL NAME Mrs Minnie, Morris

(a) RESIDENCE NO. 514 S. Smallwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Allan T. Morris

6 DATE OF BIRTH (month, day, and year): May 9th 1894

7 AGE: Years 36 Months 5 Days 26

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Henry Weinrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Valanzose

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Allen Morris

(Address) 514 S. Smallwood St.

15 C. HAMPSON JONES, M. D. Registrar

5-1930 . 19 Per ACR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-7 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-28 . 19 30 to 11-7 . 19 30, that I last saw h[illegible] alive on 11-7 . 19 30, and that death occurred, on the date stated above, at 7 11 a. m.

The CAUSE OF DEATH* was as follows:

Embolism (Brain) respiratory

(duration) yrs. 10 minutes mos. ds.

CONTRIBUTORY (Secondary) Operation (Appendectomy) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 10/28/30

Was there an autopsy? yes—

What test confirmed diagnosis? Autopsy + operation

(Signed) Nicholas R. Sanelli, M. D.

. 19 (Address) St Agnes Hosp—

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 11/7 1930

20 UNDERTAKER: John J. Cowan & Son

ADDRESS: 901 Hollins St

TION is very important.

ec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62053

CERTIFICATE OF DEATH

74-002 ✓ E 62053

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 148 Wilson ST. 14-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Irwin Stafford

(a) RESIDENCE NO. 148 Wilson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Morris Stafford

7 DATE OF BIRTH (month, day, and year) Dec 11-1867

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler inspector

(b) General nature of industry, business, or establishment in which employed (or employer) State

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pattinson Maryland

10 NAME OF FATHER W. Stafford

11 BIRTHPLACE OF FATHER (city or town) Pattinson (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Caroline Gardner

13 BIRTHPLACE OF MOTHER (city or town) Pattinson (State or country) Maryland.

PARENTS

14 Informant Mrs Amelia M Stafford

(Address) 148 Wilson St.

15 Filed 5-1930, 19 Registrar C. HAMPSON JONES, M. D.

For [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-4-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 4, 1930, that I last saw h alive on Nov. 4, 1930 and that death occurred, on the date stated above, at 11:00 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? High arterial tension

(Signed) E Blumgs, M. D.

Nov 5, 1930 (Address) 1733 Lenden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount (City)

DATE OF BURIAL 11/6 1930

20 UNDERTAKER Hughes & Jones Inc ADDRESS 424 Edmondson

Dec.—1-30—M. & T.—250 Bks

Dr Ruzicka, 4 Oak Park Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62054

CERTIFICATE OF DEATH.

113 E 62054

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1614 N Chapel ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert R. Raab

(a) RESIDENCE NO. 1614 N Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) Sept 13, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Raab

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Tomich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Charles Raab 1614 N Chapel St

15 Nov 6 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 5, 1930, that I last saw h[illegible] alive on Nov 5, 1930 and that death occurred on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows: Uremia Nephritis & Cirrhosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

(Address) 1500 N Patterson Park Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL 11/6 1930

20 UNDERTAKER W M Cook

ADDRESS 1217 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

ec.—1-30—M. & T.—250 Bks.

E 62055

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62055

CERTIFICATE OF DEATH.

111-002

1-PLACE OF DEATH Baltimore City Hosp. 22-24

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert L Woodard

(a) RESIDENCE NO. 715 E Pratt st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Lucille Woodward

7 DATE OF BIRTH (month, day, and year): Sept 14, 1866

8 AGE: Years 64 | Months — | Days — | If LESS than 1 day, ... hrs. or .... min. 21

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown.

(b) General nature of industry, business, or establishment in which employed (or employer): ? 087

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Colorado.

PARENTS

10 NAME OF FATHER: Robt. L. Woodard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Matilda Woodard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio.

14 Informant: Friend (Address) Baltimore City Hosp.

15 Filed 5 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from 11-3-, 1930, to 11-3-, 1930, that I last saw h— alive on 11-3-, 1930, and that death occurred, on the date stated above, at 10½ A m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinoma

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Ruptured duodenal ulcer

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? yes Date of 11-3-30

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings.

(Signed) Fred M. Smith, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: 11/7 1930

20 UNDERTAKER: J M Cook

ADDRESS: 1217 E Pratt St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62056

90 E 62056

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Jail. St., 25-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Emmerich.

(a) RESIDENCE NO. 1518 Sycamore St. Curtis Bay. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced, HUSBAND of XXXXXXXXXX Antionette Emmerich.

6 DATE OF BIRTH (month, day, and year) December 3, 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
O.M.R.	44 ~~46~~	11	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) New York.
(State or country)

PARENTS

10 NAME OF FATHER John Emmerich.

11 BIRTHPLACE OF FATHER (city or town) New York.
(State or country)

12 MAIDEN NAME OF MOTHER Johanna Rosenwather.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant (Address) Antionette Emmerich. (wife) 1518 Sycamore St. Curtis Bay.

15 DATE RECEIVED 1930 H. SIMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leonhardt, M. D.

11/5, 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, A.M.C.

DATE OF BURIAL 11/6 1930

ADDRESS 1217 E. Pratt St.

20 UNDERTAKER J. Wm. Cook

Important. See instructions on back of certificate.

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 E 62057

E 62057

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH Maryland General Hospital. ST. 9-18 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. .....

2—FULL NAME Mrs. Annette Bowers

(a) RESIDENCE NO. 1001 E. Lanvale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Blaney

DATE OF BIRTH (month, day, and year) June 12, 1897

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	4	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER George W Blaney

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Aby

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania
(State or country)

14 Informant Hospital Records

(Address)

15 Filed 5-1930, 19 THOMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 5 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-31-1930, to 11-5-1930, 19

that I last saw h[illegible] alive on 11-5-30, 19

and that death occurred, on the date stated above, at 11.31 A.m.

The CAUSE OF DEATH* was as follows:

Tumor, right cerebral temporo-[illegible]

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-3-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) John T. Chenault, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

20 UNDERTAKER W M Cook

DATE OF BURIAL 11/8 1930

ADDRESS 1217 E Fond St

Spec.—1-10-21—M&T—1500 Bks.

E 62058 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62058

CERTIFICATE OF DEATH. 90

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Wilkins & Caton Ave ST. 70-70 WARD)

2-FULL NAME John Schalitzky

(a) RESIDENCE NO. 103 Morley st. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Schalitzky

6 DATE OF BIRTH (month, day, and year) Dec 4 1847

7 AGE Years 82 Months 11 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Schalitzky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mysmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mollie Sullivan

(Address)

15 Filed 5-1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-3- 1930 to 11-5 1930.

that I last saw h~~e~~ alive on 11-5 1930

and that death occurred, on the date stated above, at 11-5 7 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio Vascular disease with cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Robt Herman, M. D.

19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 11/8 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Lanvale

sec.—1-30—M. & T.—250 Blks

62059

E 62059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62059

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

2-FULL NAME Mary Brandenburg

(a) RESIDENCE NO. Elliott City, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	married

a If married, widowed, or divorced HUSBAND of, or) WIFE of Chas. Brandenburg

6 DATE OF BIRTH (month, day, and year) May 22 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land.

PARENTS

10 NAME OF FATHER Daniel Roback

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Ronald Brandenburg.

(Address) Ellicott City Md.

15 Filed 6-1930 R. K. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov. 6, 1930, that I last saw h Le alive on Nov. 6, 1930, and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 15 yrs. mos da.

CONTRIBUTORY (Secondary) Cellulitis of left arm; Septicaemia (duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Yes Date of Nov. 3. 1930.

Was there an autopsy? no

What test confirmed diagnosis? Laboratory tests, culture

(Signed) G. J. Brosius Jr. M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cem

DATE OF BURIAL 11-9 1930

20 UNDERTAKER H. E. Shumbathon

ADDRESS Ellicott City

ec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 62060

E 62060

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 N. Fremont ST.; 17th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Ann Steele

(a) RESIDENCE NO. 727 N. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

DATE OF BIRTH (month, day, and year): Nov 15 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	70	11	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Jeremiah Tuttle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Mary Ann Steele

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs. Nannie E. Fenby

(Address) 727 N. Fremont St.

15 Filed Nov 5 1930 H. NELSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 4. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2 1930 to Nov. 4 1930

(Sat.) last saw her alive on Nov. 4 1930

and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Senility 2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur Bell M. D.

, 19 (Address) 1 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnson Cemetery

DATE OF BURIAL: 11-7 1930

20 UNDERTAKER: John H. Toadvine

ADDRESS 1027 Hanover

rec.—1-30—M. & T.—250 Blks

E 62061

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62061

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Emma Booth

(a) RESIDENCE NO. 1511 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1869

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Dan Gately

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Henretta Lincoln

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

Filed 6-1930, 19 H. HOOK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from 9-26-29, 19.., to 11-3-30, 19..,

that I last saw him alive on 11-3-30, 19..,

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Vincent's Angina; mouth and lungs.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic. Hypertension (duration) yrs. 13 mos. ds.

18 Where was disease contracted if not at place of death? 1. Hospital 2. Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Podell, M. D.

11-7, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 11-6 1930

20 UNDERTAKER John H. Jordan

ADDRESS 1027 Hanover

ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62062 ✓ 24001 E 62062

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Sanatorium ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Harriet Berry

(a) RESIDENCE NO. 34-E-26 St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? 70 yrs. —mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced (HUSBAND of or) WIFE of: Single

7 DATE OF BIRTH (month, day, and year): About 1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 70		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Jesse Lee Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mary E. Koslin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. W. F. Sellman (Mother)

(Address): 211 Edendale Road

Filed NOV 6 - 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov - 5/30

17 I HEREBY CERTIFY, That I attended deceased from October 17, 1930, to November 5, 1930, that I last saw her alive on November 3, 1930 and that death occurred, on the date stated above, at 7 am m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) one yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. M. Gehle M. D.

11/5, 1930 (Address) 245 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Cemetery DATE OF BURIAL: Nov-7, 1930

20 UNDERTAKER: Stewart & Mowen Co ADDRESS: 108-10 North Ave

Cor—12-9-25—A Co—200 Bks.

E 62063

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62063

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH: City of BALTIMORE: (No.) Pronounced dead at Salt City Hos. St., 9-47 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Jackson Barringer

(a) RESIDENCE NO. 608-E-34th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): abt. May-8-1855

7 AGE: Years: about 8[illegible] Months: 5 Days: 24 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Watchman for
(b) General nature of industry, business, or establishment in which employed (or employer): Donahue Bldg
(c) Name of employer: Company

9 BIRTHPLACE (city or town): Baltimore
(State or country): Maryland

PARENTS

10 NAME OF FATHER: Andrew J. Barringer

11 BIRTHPLACE OF FATHER (city or town): Balto.
(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah Litsinger

13 BIRTHPLACE OF MOTHER (city or town): Balto.
(State or country): Maryland

14 Informant (Address): Mrs. B. A. Wilson (Niece) 608 Bartlett Ave

15 Filed: 6-3-1930, 19.. Registrar: HAMILTON JONES, M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. 15 Min's

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) 3 yrs. ..... mos. ..... ds.

(Signed) James McPherson M. D. (Coroner)

May 3, 1930 (Address) 701 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death — yrs. — mos. — ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 608-E-34th Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: May 6 1930

20 UNDERTAKER: Stewart & Mowen Company — ADDRESS: 108-10 North

Rec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62064

CERTIFICATE OF DEATH.

E 62064

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 530 Bruce ST. 17-26 (WARD)

2-FULL NAME Sarah Adams

(a) RESIDENCE NO. 530 Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of James Adams

7 DATE OF BIRTH (month, day, and year) Jan 10, 1870

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jacob Cayce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Virginia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Jane Adams

(Address) 530 Bruce St

15 Filed Nov 6 1930 H. LESTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1930, to Nov 4, 1930

that I last saw h alive on Nov 4, 1930

and that death occurred, on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Cayce, M. D.

, 19 (Address) 1917 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 11-6 1930

20 UNDERTAKER David Carlson

ADDRESS Dear

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62065 90 E 62065

E 62065

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (NO. 438 Conway ST., 11-30 WARD)

2-FULL NAME Frank Cooper

(a) RESIDENCE NO. 438 Conway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Col	Married.

6 If married, widowed, or divorced HUSBAND of or) WIFE of Florence Cooper,

DATE OF BIRTH (month, day, and year) March 4 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	-7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ono

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Florence Cooper

(Address) 438 Conway St

15 Filed 11-6-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 4, 1930, that I last saw him alive on Nov 3, 1930, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? H. Mead

(Signed) H. Mead M. D.

11/6, 1930 (Address) 709 Dumbarton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 11-6-1930

20 UNDERTAKER Dennis Carter

ADDRESS 916 Dr one.

G. MACKALL JONES, M. D.

30—M. & T.—100 B—50L

George Welsh

E 62066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 62066

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Hopkins Hospital St. 12-19 WARD)

2-FULL NAME George Welsh

(a) RESIDENCE NO. 1609 Barclay St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	w. hite	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer) Ret
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary McCauley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant 1609 Barclay St.
(Address)

15 Filed NOV 6 - 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3-4 ds.

CONTRIBUTORY (Secondary) Cardio-Renal Disease (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. W. Culler, M. D. Coroner

, 19 (Address) 608 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Nov. 7 1930

20 UNDERTAKER L. Rich

ADDRESS [illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62067

CERTIFICATE OF DEATH

90 E 62067

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 117 S.Liberty St. St. 4-30 Ward)

2-FULL NAME Thomas J.Murn.

(a) RESIDENCE NO. 117 S.Liberty St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) May 22, 1903

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	27	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward J.Murn.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Brannan.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Edward J.Murn.(father)
(Address) 117 S.Liberty St.

15 Filed 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) November 3, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leonhardt, M. D.

11/5, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 11-7th, 1930

20 UNDERTAKER Bernard C. Harke

ADDRESS 1000 S Paca St.

important. See instructions on back of certificate.

c.—1-30—M. & T.—250 Bks

E 62068 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62068

REGISTERED NO.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 2438 Jones ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Jackson

(a) RESIDENCE No. 2438 Jones ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Susian Jackson

DATE OF BIRTH (month, day, and year) June 1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Belona Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Robert Jackson (Address) 2438 Jones St.

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-30

17 I HEREBY CERTIFY, That I attended deceased from 11-3- 1930 to 11-5- 1930, that I last saw him alive on 11-5- 1930, and that death occurred, on the date stated above, at 1:20 A.m.

The CAUSE OF DEATH* was as follows:

Cerebal hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Endocarditis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frank A Saunders M. D.

11-6- 1930 (Address) 1029 n. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Nov. 8, 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1715 Eastlan

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62069

CERTIFICATE OF DEATH.

161-001

E 62069

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp. ST. 4-27 WARD)

2-FULL NAME Baby Boy Johnson

(a) RESIDENCE NO. 514 N Chatham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): New born

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 27. 1930

7 AGE: Years | Months | Days | If LESS than 1 day 1 hrs. 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: New born

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): University Hosp Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Naomi Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mother

(Address)

Filed 6-1930, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Oct 27, 1930, that I last saw h alive on Oct 27, 1930, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cesarean Section

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & Phys Exam

(Signed) [illegible] M. D.

10/31/1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: NOV 5 1930, 19

20 UNDERTAKER

ADDRESS

Commissioner Health

Per Wm E. Woodall.

C.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62070

CERTIFICATE OF DEATH.

161001

E 62070

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 747 Dolphin ST. 17-24 WARD)

2-FULL NAME Baby James

(a) RESIDENCE NO. 747 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occ[urred] Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 3-30

AGE	Years	Months	Days	If LESS than 1 day 20 hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Louise Dawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Louise James
(Address) 747 E Dolphin St

15 Filed NOV 6 - 1930 Registrar HAROLD JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4-30

17 I HEREBY CERTIFY, that I attended deceased from Nov 3. 1930 to Nov 4 1930, that I last saw h[im] alive on Nov 4 1930 at 8.30 A m. and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Both Lungs

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Address 928 N Eutaw St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
NOV 5 1930
HEALTH COMMISSIONER

1-30—M. & T.—250 Blks

E 62071 HEALTH DEPARTMENT—CITY OF BALTIMORE 74 of E 62071

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Charles Heard

(a) RESIDENCE NO. 908 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Oct. 21 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Wm. Heard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

PARENTS

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-4-30

17 I HEREBY CERTIFY, That I attended deceased from 10-29-28 . 19 . to 11-4-30 . 19 , that I last saw him alive on 11-4-30 . 19 , and that death occurred, on the date stated above, at 4:15 P.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Hypertension and arteriosclerosis more than (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1. Hospital 2. House.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Paget. M. D.

11-4-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

20 UNDERTAKER Philip Herwig

DATE OF BURIAL Nov 6/30 19

ADDRESS 2016 Edmondson Ave

C—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62072

CERTIFICATE OF DEATH.

90 E 62072

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1716 N Milton Ave ST. 8 WARD)

2-FULL NAME Elizabeth Euler

(a) RESIDENCE NO. 1716 N Milton Ave ST. 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Euler

DATE OF BIRTH (month, day, and year) March 1 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	69	8	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Lewis Kirsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry L Euler (Address) Greenwood Ave

15 Filed NOV 6 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 , 1930 , to Nov 4 , 1930 , that I last saw h[illegible] alive on Nov 4 , 1930 , and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) B B Herzog md M. D.

11/4, 1930 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Nov 7, 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

c.—1-30—M. & T.—250 Bks

62073 HEALTH DEPARTMENT—CITY OF BALTIMORE 3/ E 62073

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 N. Strupe ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Estelle Saloman

(a) RESIDENCE NO. 124 N. Strupe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of none

DATE OF BIRTH (month, day, and year) Aug 8/1912

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	2	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Henry Saloman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Henry Saloman

(Address) 124 N. Strupe St

15 Filed NOV 6 - 1930 H. Leslie Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5/30

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1930, to Nov. 3 - 1930, that I last saw her alive on Nov. 2, 1930, and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis

Chronic. Dis Heart (Mit Reg.)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav C. Thiemel, M. D.

, 19 (Address) 16 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem

DATE OF BURIAL Nov 7 19 30

20 UNDERTAKER Phillips Herwig

ADDRESS 2016 Orleans St

c.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62074

CERTIFICATE OF DEATH

128 VE 62074

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 418 N. Dallas ST. 6-4 WARD)

2—FULL NAME Daniel Williams

(a) RESIDENCE NO. 418 N. Dallas ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colord	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of Single

DATE OF BIRTH (month, day, and year) 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizebeth Sanduce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Moses Williams
(Address) 418 N. Dallas st

15 Filed 6-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 5, 1930, that I last saw h~~im~~ alive on Nov. 5, 1930 and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) ✓ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) W. S. Taylor, M. D.

Nov 11, 19 (Address) 1522 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary cemetery — DATE OF BURIAL Nov 8 1930

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

Cor.—10-10-29—A Cc.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2075

CERTIFICATE OF DEATH

E 62075

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp St. 11-24 Ward)

2-FULL NAME Amos Alvis Warner

(a) RESIDENCE NO. Frizzelburg Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Minnie Warner

6 DATE OF BIRTH (month, day, and year) Feb 7-3-1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	54	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co
(State or country)

PARENTS

10 NAME OF FATHER Saml J. Warner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Houck

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Minnie M. Warner
(Address) Westminster Md

15 Filed ..... 19.. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Truck on which he was a driver struck by coupler & flown from truck to road

(duration) yrs. mos. ds.

Fract Skull

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Taneytown Pike

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L E Frame, M. D.

11 5 1930 (Address) 2039 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Frederick

DATE OF BURIAL Nov 7 1930

20 UNDERTAKER C. D. Fuss & Son

ADDRESS Taneytown Md

Important. See instructions on reverse side.

—1-30—M. & T.—250 Bks.

41965
Pad 62076

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62076

CERTIFICATE OF DEATH.

159-003

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 4-30 WARD)

2-FULL NAME Ida Singer (Baby)

(a) RESIDENCE NO. 104 S. Paca St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE: Years | Months | Days: 11 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ida —

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1930, to Nov 4, 1930, that I last saw h.. alive on Nov 4, 1930, and that death occurred, on the date stated above, at 11:10 p. m.

The CAUSE OF DEATH* was as follows: Congenital anomaly Pylorus 4 Weeks obstruction

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-23-30

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) H. Gadsden, M. D.

11/6, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship

DATE OF BURIAL: 11-6-30

ADDRESS 1459 E. Baltimore

20 UNDERTAKER: Jack Lewis

C. H. Jones, M. D. Registrar

Combs

Spec.—1-10-21—M&T—1500 Bks.

77

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62077

CERTIFICATE OF DEATH.

129

REGISTERED NO. 2755

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5231 Dewmare Ave. (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Combs.

(a) RESIDENCE No. 5231 Dewmare Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm L. Combs

6 DATE OF BIRTH (month, day, and year): Jan 16/1874

7 AGE: 56 Years 11 Months 14 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Owen Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Maria LaCount

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Luther B. Combs

(Address) 5231 Dewmare Ave

15 [illegible]

6 - 1930 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 30 1930 to Nov 4th 1930.

that I last saw her alive on Nov 4th 1930,

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Carcinomatous Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Leo. H. Langenbacher M. D.

(Address) 221 N. Howard Ave. 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. | DATE OF BURIAL: Nov. 7 1930

20 UNDERTAKER: Geo. J. G. Gibson | ADDRESS: 1335 Druid Hill Ave

—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62078

E 62078

CERTIFICATE OF DEATH

REGISTERED NO. 44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 504 N. Carrish St. (WARD) 19-27

2—FULL NAME Georgeanna Comish

(a) RESIDENCE NO. 504 N. Carrish St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Widow

If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Benjamin Cornish

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

10 NAME OF FATHER Geo. W. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ked.

12 MAIDEN NAME OF MOTHER Louisa Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Catherine Jefferson

(Address) 504 N. Carrish St.

15 Filed 6-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4/30

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to Nov 4, 1930, that I last saw her alive on Nov 4, 1930 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank E. Wagner M. D.

11/5, 1930 (Address) 625 Schroeder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Nov 8th 1930

20 UNDERTAKER A. Jones — ADDRESS 111 S Gilmor

—1-30—M. & T.—250 Bks

E 62079 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62079

CERTIFICATE OF DEATH.

REGISTERED NO. 2540

1-PLACE OF DEATH Jenkins Memorial Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1000 Caton Ave ST., 25 WARD)

2-FULL NAME Margaret V. Murphy

(a) RESIDENCE NO. 253 South 55th St. Rid. 46 ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of Chas. J. Murphy

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77 yrs	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thos. Fryer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mathilda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jenkins Memorial Hospital
(Address) 1000 Caton Avenue

15 Filed NOV 8 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1927, to November 5, 1930, that I last saw h... alive on , 1930, and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Arthritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Hjalmar S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/7 1930

20 UNDERTAKER Century U. Mears and Son

ADDRESS 805 N. Calvert

—1-30—M. & T.—250 Bks

E 62080

E 62080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals (No. 19-28 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

2-FULL NAME August Schnlle

(a) RESIDENCE NO. 1718 McHenry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of Single

DATE OF BIRTH (month, day, and year) Mar. 24, 1857

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	7	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of
(Address) Baltimore City Hospitals

Filed NOV 6- 1930 ALAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5-30

17 I HEREBY CERTIFY, That I attended deceased from 11-3-30, 19 ..., to 11-5-30, 19 ..., that I last saw him alive on 11-5-30, 19 ..., and that death occurred, on the date stated above, at 5:50 A. m.

The CAUSE OF DEATH* was as follows:

Heart disease.
arteriosclerotic
(duration) more than 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency
anginal (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Padget, M. D.

11-5-30, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov 8 1930

20 UNDERTAKER George L. Schwab

ADDRESS 210 Park Ave.

-1-30—M. & T.—250 Bks

E 62081 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62081

113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No.) 1714 Johnson ST. 24-34 WARD)

-FULL NAME Herbert Leon Dorsey

(a) RESIDENCE NO. 1714 Johnson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) 3/4/1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	-	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Chas D. Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Lillian V. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant (Address) Mr Chas D. Dorsey 1714 Johnson St.

6 - 1930 Filed 19 C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26 H/M 1930 to Nov. 4 1930,

that I last saw h[illegible] alive on Nov. 4 1930,

and that death occurred, on the date stated above, at 10:00 A m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos 9 ds.

Exhaustion

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. E. Campbell M. D.

11/5 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. E. Campbell

DATE OF BURIAL 11/7 1930

20 UNDERTAKER John F. Haley Sons

ADDRESS 1218 Light St

...—1-30—M. & T.—250 Blks.

E 62082 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62082

CERTIFICATE OF DEATH. X 153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hosp. 33rd, Calvert St. (ST.) 49 (WARD)

REGISTERED NO. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adella Ross

(a) RESIDENCE NO. Darlington Md ST., WARD Maryland. (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? — yrs. 2 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single.

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Feb. 9, 1929

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1		8	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Wilbur Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Maude Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Records (Address)

15 - 1930, 19... C. HAMPSON JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from November 3, 19 30, to November 5 19 30, that I last saw h[er] alive on November 5, 19 30, and that death occurred, on the date stated above, at 11 25p m.

The CAUSE OF DEATH* was as follows:

Staphylococcus septicaemia

~~Cardiac failure~~.

(duration) 0 yrs. 0 mos 3 ds.

CONTRIBUTORY (Secondary) ~~Septicaemia~~ Generalized Tuberculous disease (duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? Darlington Maryland 11-3-30

Did an operation precede death? Yes Date of 11-5-30

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory findings. + autopsy

(Signed) Jesse [illegible] Foster, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brook Cem DATE OF BURIAL Nov. 8, 19 30

20 UNDERTAKER H. L. Bailey ADDRESS Darlington Md

K. B. Boyd 104 W. Madison

...—1-30—M. & T.—250 Bks

E 62083

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62083

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3117 Belvadere St. (or) Ward

2-FULL NAME Richard James Hulett

(a) RESIDENCE NO. 3117 Belvadere ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

DATE OF BIRTH (month, day, and year) Feb 26 1878

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	52	7	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) B & O

(c) Name of employer B & O R.R.

BIRTHPLACE (city or town) (State or country) U.S.

PARENTS

10 NAME OF FATHER David Kenna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Kenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Paul Hadaway

(Address) 3117 Belvadere

15 Filed 6-1930 19 C. HAMPSON JONES, M.D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1930, to Nov. 5, 1930,

that I last saw h[illegible] alive on Nov. 5, 1930,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis + Nephritis

(duration) 3 yrs. mos da.

CONTRIBUTORY (Secondary) Edema of Lungs (duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Physical Exam.

(Signed) E. B. Boyd M. D.

, 19 (Address) 104 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cook Roman Catholic Nov 8 1930

DATE OF BURIAL

20 UNDERTAKER Effie Cook

ADDRESS 217 St. Paul

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62084 — 90 ✓ — E 62084

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3705 N. Charles ST. 12-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles L. Hilgartner

(a) RESIDENCE NO. 3705 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced: HUSBAND of (or) WIFE of Katherine E. Hilgartner

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
69	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) President

(c) Name of employer Hilgartner Marble Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Ludwig Hilgartner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda Schrodel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

Informant Mr. Andrew H. Hilgartner

(Address) 1 W. Kenwood Road

Filed ...-1930 C. PLIMPTON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8 . 1929, to Nov 4 . 1930, that I last saw h im alive on Nov 4 . 1930 and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis - Arteriosclerosis

(duration) 3 yrs. — mos. ds.

CONTRIBUTORY (Secondary) Hypertension of long standing (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Sydney R. Miller, M. D.

11/5, 1930 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Nov. 7 1930

20 UNDERTAKER Joseph Cook

ADDRESS 1003 West Baltimore St.

For.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62085

E 62085

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq Hospital St., Ward)

2-FULL NAME Mrs L M. Mary E. Strodt Strodt

(a) RESIDENCE NO. 1422 Holliday St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13, 1865

7 AGE: Years 65 68 | Months 3 | Days 23 21 | IF LESS than 1 day.... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: H W
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer: Md

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter H Strodt

11 BIRTHPLACE OF FATHER (city or town) Ger-
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Hummel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Karl L Strodt
(Address) Catonsville

15 Filed 1930 19 C. HARRISON JONES Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
a Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Brooke M. D.

Oct 8, 19 30 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Nov 8" 1930

20 UNDERTAKER: Joseph B Cook — ADDRESS: 1003 W Balto St

...—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

62086 E 62086

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 7-3-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.

2-FULL NAME Emmanuel Morris

(a) RESIDENCE NO. 1026 S. Sharpst. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Morris

DATE OF BIRTH (month, day, and year) Jan. 1, 1906

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	9	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Lake Landing North Carolina

10 NAME OF FATHER Athen Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Nita Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed 6-1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to Oct. 21, 1930, that I last saw him alive on Oct. 21, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis, acute.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Seaman, M. D.

10-22-30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

NOV 6 1930

Commissioner of Health

or.—10-10-29—A Co.—100 Bks.

E 62087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 62087

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) South Baltimore General Hospital 17-26 Ward

2-FULL NAME Francis Cavenall.(C)

(a) RESIDENCE NO. 414 Brune St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	22	---------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report S.D.
(Address)

15 Filed ---, 19--- Per ---- Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19.1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Accidental fall while intoxicated.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hanover & Camden Sts October 18, 1930

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & inquiry

(Signed) Otto M. Eichhardt, M. D.

11/5, 19 30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

C. HARTSON JONES, M. D.

NOV 1930

1930

or.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 62088

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 62088

1-PLACE OF DEATH

City of Baltimore: (No. 314 Bethel Court. St., 4-7 Ward)

2-FULL NAME Lilliam Wyatt.(C)

(a) RESIDENCE NO. 314 Bethel Court. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Colcred	Married

5a If married, XXXXXXXXXXXX (or) WIFE of James Wyatt.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	-------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant James Wyatt.(C) husband.
(Address) 314 Bethel Court.

15 Filed ..... 19 ..... C. P. NELSON JONES, M. D. Registrar

6 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 18, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt M. D.

11/5. 19 30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

NOV 6 1930

THE MORGUE

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62089

CERTIFICATE OF DEATH

90 E 62089

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2619 Fait Ave ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maryanna Krupska

(a) RESIDENCE NO. 2619 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

If married, widowed, or divorced: HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year): Feb. 2 18 55

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75 85		9		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Poland Germany

10 NAME OF FATHER: Albert unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: John Dembeck

(Address): 2619 Fait Ave

Filed 6-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930, to Nov 4, 1930, that I last saw her alive on Nov 4, 1930 and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Litton, M. D.

11/5 1930 (Address) 314 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Nov 7 1930
20 UNDERTAKER: Stephen J. Feathers Inc	ADDRESS: 1000 d. Cem

2.—1-30—M. & T.—250 Bks.

62090

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62090

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Windsor Court Apt. ST., 15-64 WARD)

2-FULL NAME Margaret Heuisler Cook

(a) RESIDENCE NO. Windsor & Garrison Ave. Windsor Court Apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced (HUSBAND of or) WIFE of Frederick C. Cook

DATE OF BIRTH (month, day, and year) Apr. 23 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Jos. S. Heuisler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine McCann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

PARENTS

14 Informant Victor Cook

(Address) 3412 Gwynn Falls Parkway

Filed NOV 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-31 , 1930 , to 11-5 , 1930 .

that I last saw h~~e~~r alive on 11-5 , 1930

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Bronco-pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) C. Neal Ebeus M. D.

, 19 (Address) Windsor Court Apts. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/8 1930

20 UNDERTAKER Chas. S. Trautsch Son

ADDRESS 1811 N. Royal Ave

ec.—9-30—A. & Co.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

62091 CERTIFICATE OF DEATH. 75-001 62091

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No 116 N Payson ST. 20-27 WARD

2 FULL NAME Mary Flynn

(a) RESIDENCE NO. 116 N Payson ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Dominick Flynn

7 DATE OF BIRTH (month, day, and year) Feb 2 1860

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	2	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) England

PARENTS

11 NAME OF FATHER John Feeney

12 BIRTHPLACE OF FATHER (city or town) (State or country) England

13 MAIDEN NAME OF MOTHER Mary Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Cath. Flynn
(Address) 116 N Payson St

15 FILED 6-1930, 19 By C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/4/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Nov 4, 1930, that I last saw h alive on Nov 4, 1930, and that death occurred, on the date stated above, at 2-10 P. M.

The CAUSE OF DEATH* was as follows:

Hemaphelgia (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E Keller Hennessy M. D.

11/5, 1930 (Address) 2000 Hollins St

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 11/5 1930

20 UNDERTAKER Forget & Farley Fulton & Fayette ADDRESS

—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62092

CERTIFICATE OF DEATH

129 ✓ E 62092

REGISTERED NO. 5567

—PLACE OF DEATH

Y OF BALTIMORE: (No. 4804 Park Heights ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Elizabeth Barker

(a) RESIDENCE NO. 1910 Longwood ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) about 1867

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 63			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER William B. Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Francis Baran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant George A. Moore

(Address) 270 Fenwick Ave

FILED 1930 C. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) nov-6-30

17 I HEREBY CERTIFY, That I attended deceased from march 28, 1930, to nov 6, 1930.

that I last saw h[illegible] alive on nov 5 1930

and that death occurred, on the date stated above, at 7.90 A m.

The CAUSE OF DEATH* was as follows:

Chronic intestinal nephritis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. A. Zimmerman M. D.

11/6, 1930 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem DATE OF BURIAL Nov. 8, 1930

20 UNDERTAKER H. Garnet Evans ADDRESS 3015 Gatewood

—1-30—M. & T.—250 Bks.

62093 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62093

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH CHURCH HOME AND INFIRMARY

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. N Broadway ST. 14 WARD)

2-FULL NAME TURNER, FANNIE Vallaint

(a) RESIDENCE NO. 141 E Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Wm Warfield Turner

DATE OF BIRTH (month, day, and year) May 18, 1853

AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	77	5	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Tennessee

10 NAME OF FATHER Wm Wallace Vallaint

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alexine LeCompte

13 BIRTHPLACE OF MOTHER (city or town) Louisville (State or country) Ky

14 Informant VALIANT, Wilsie M.

(Address) 141 E. Linden Ave

15 Filed 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 31st, 1930, to November 5th, 1930, that I last saw her alive on November 5, 1930, and that death occurred, on the date stated above, at 8 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

Immediate. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Auricular fibrillation; Chronic myocard. tis (duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? NOT KNOWN

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs.

(Signed) J. Frank Hewitt, M. D.

11/5. 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bellevue Talbot Co Md

DATE OF BURIAL Nov. 7 1930

20 UNDERTAKER Wm H. Tucker & Sons

ADDRESS Rockville

M. & T.—100 B—50L

2094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-00E 62094

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp. ST. WARD)

2. FULL NAME James Curtis.

(a) RESIDENCE 2552 Druid Hill Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married.

married, widowed, or divorced HUSBAND of (or) WIFE of Cassandra —

6 DATE OF BIRTH (month, day, and year) Oct 12 1892

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38		23	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Garage owner
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER John Curtis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Howard.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Cassandra Curtis

(Address) 2552 Druid Hill Av

Filed ..., 192. HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos 3 ds. Acute Intestinal Obstruction

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Feuchtwanger, M. D. Coroner

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Nov 7 1930

20 UNDERTAKER: Mrs Geo H. Holland

ADDRESS: 1431 Druid Hill Av

—1-30—M. & T.—250 Bks.

62095

HEALTH DEPARTMENT—CITY OF BALTIMORE

101500 E 62095

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 1207 Edyth ST. 5-8 WARD)

2-FULL NAME Mary Lillian Hill Hunt

(a) RESIDENCE NO. 1207 Edyth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Williams Hunt

DATE OF BIRTH (month, day, and year) Oct 1 1901

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	One	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Emerson Hotel

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Lorenza Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Ridgely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

4 Informant Florence Hill

(Address) 1207 Edyth St

C. HARRISON JONES, M.D.

Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov 5, 1930,

that I last saw her alive on Nov 5, 1930,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no Physical evidence

What test confirmed diagnosis?

(Signed) Geo Alden, M. D.

11-8 1930 (Address) 508 Somerset

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem.

DATE OF BURIAL 11-8 1930

ADDRESS

20 UNDERTAKER Byron Wright 1218 Mc Elderry St

—1-30—M. & T.—250 Bks

62096

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62096

CERTIFICATE OF DEATH.

3 1 v

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. ST. 10-Ad WARD)

2-FULL NAME Edward Ware (Weirs)

(a) RESIDENCE NO. 920 Aisquity st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Weirs

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
31	30	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Copper Works

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) South Carolina

10 NAME OF FATHER Thomas Weirs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Louise Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 7-1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to Nov. 3, 1930, that I last saw him alive on Nov. 3, 1930, and that death occurred, on the date stated above, at 7.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Lucas, M. D.

11-4 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery Cem

DATE OF BURIAL 11 7 1930

20 UNDERTAKER Bynum Wright 1218 McElderry St

ADDRESS

1-30—M. & T.—250 Bks

E 62097 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62097

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. B ST., 1-N WARD)

2-FULL NAME Lewis Zulauf

(a) RESIDENCE NO. 613 S. Curley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year) April 28, 1851

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Lewis Zulauf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Records of

(Address) Balto. City Hosp.

Filed 7-1930 C. HAMPSON JONES, M.D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5-30

17 I HEREBY CERTIFY, That I attended deceased from 7-29-26, 19..., to 11-5-30, 19...

that I last saw him alive on 11-5-30, 19...

and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

Heart disease, arteriosclerotic

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padgett, M. D.

11-6, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Nov. 8 1930

20 UNDERTAKER Fairey Hearse Sons, Inc. ADDRESS 1301 E Eager St

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62098 161-001

REGISTERED NO. E 62098

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) 516 St. Mary's St. ST. 17th (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Hart

(a) RESIDENCE NO. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): 10/28/30

7 AGE: Years — Months — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Carol Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Francis Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address)

15 Filed 7-1930 19 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/29/30 19

17 I HEREBY CERTIFY, That I attended deceased from 10/28/30, 19, to 10/29/30, 19,

that I last saw him alive on 10/29/30, 19,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

maturus ictamperia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical picture

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Retained by Hospital

DATE OF BURIAL 19

ADDRESS

UNDERTAKER

Spec. 1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62099

CERTIFICATE OF DEATH.

E 62099

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 13-59 WARD)

2-FULL NAME Baby Girl Cumberton.

(a) RESIDENCE NO. 2407 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: new born

7 DATE OF BIRTH (month, day, and year): Nov 1, 1930

8 AGE — Years: — Months: — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: New born infant.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Edwin Cumberton.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sparta Ga.

12 MAIDEN NAME OF MOTHER: Annie Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sparta Ga.

14 Informant (Address): Annie Cumberton 2407 Madison Ave.

15 Filed 7-1930 E. H. [illegible] JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1930, to Nov 2nd 1930,

that I last saw h[illegible] alive on Nov 1st 1930,

and that death occurred, on the date stated above, at 1 o'clock p m.

The CAUSE OF DEATH* was as follows:

Intra cranial hemorrhage -

(duration) yrs. mos 1 ds. died

CONTRIBUTORY - (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? University Hospital

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Blood & Lung exam.

(Signed) [illegible] M. D.

11-3-1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Released by Hospital

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62100

CERTIFICATE OF DEATH.

101-006 E 62100

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1405 Kuper Place ST. 14-28 (WARD)

2-FULL NAME Francis Eugene Bell

(a) RESIDENCE NO. 1405 Kuper Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) May 28-1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Charles H. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Ethan A. Bell (Address) 1405 Kuper St.

15 Filed 1930 H. A. JONES, M. D. Registrar

Ent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30th. 1930, to Nov. 5th. 1930, that I last saw h im alive on Nov. 5th. 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Clinical

(Signed) Edw. J. Cavoli M. D.

11/6 1930 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL 11/7 1930

20 UNDERTAKER Harry H. Weitzke, 4101 Edmondson Ave

ADDRESS

spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62101

E 62101

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1923 Wilkens Ave. ST. (WARD) 21-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John O. Myers

(a) RESIDENCE NO. 1923 Wilkens Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma J. Myers(nee Cavey)

6 DATE OF BIRTH (month, day, and year) June 21,1866.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
64	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER J. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elmira Cavey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Emma Myers

(Address) 1923 Wilkens Ave

Filed V7-1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/10 1930 to 11/5 1930, that I last saw h[illegible] alive on 11/5 1930, and that death occurred, on the date stated above, at 3:10 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's, Ellicott City

DATE OF BURIAL 11/7/30

UNDERTAKER Harry A. Wirtz

ADDRESS 4101 EdmondsonAve

Spec.—1-10-21—M&T—1500 Bks.

E 62102 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 129 E 62102

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 437 E. Lanvale St. (St.) 12-19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Turner

(a) RESIDENCE NO. 437 E. Lanvale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel H. B. Turner

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1857.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Samuel H. B. Turner

(Address) 437 E. Lanvale St.

15 Filed 1930 C. HAMPTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1928, to Nov. 5, 1930, that I last saw her alive on Nov 5 1930, and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Edw. L. Finnerman M. D.

11-6 1930 (Address) 2858 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Abingdon Cem. Harford Co. DATE OF BURIAL 11/9/30

20 UNDERTAKER Harry H. Witzke. ADDRESS 4101 Edmondson Ave.

—1-30—M. & T.—250 Bks.

62103

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 62103

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Mem Hospital

TY OF BALTIMORE: (No. ..... ST. 11-19 WARD)

2-FULL NAME Frederick Hugo Pleumacher

(a) RESIDENCE NO. 206 E Preston St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Mrs Frederick Pleumacher

ATE OF BIRTH (month, day, and year) Sept 1, 1860

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	2	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Fred Julius Pleumacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Kupper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant A. C. Pleumacher

(Address) 206 E Preston St

Filed ..... 19 ..... M. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 to ..... 19 30.

Nov 6 to ..... 19 30, to Nov 6 ..... 19 30,

that I last saw h alive on Nov 6 ..... 19 30,

and that death occurred, on the date stated above, at 9:00 P m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia 4d

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Frances H Black, M. D.

11 6 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL 11/7 1930

20 UNDERTAKER J. M. Cook

ADDRESS 127 St Paul St

—1-30—M. & T.—250 Blks.

23930 4 E 62104

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001 E 62104

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 15-21 WARD)

2-FULL NAME Maude Wingate

(a) RESIDENCE NO. 1527 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Married

If married, widowed, or divorced (or) HUSBAND of / WIFE of Wm

DATE OF BIRTH (month, day, and year) June 22 - 1897

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	11	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NW 097

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Columbus Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 C. H. Hoff JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6-1930

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Nov 6, 1930, that I last saw h[illegible] alive on Nov 6, 1930, and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 10-5-30

Was there an autopsy? no

What test confirmed diagnosis? clinical diagnosis

(Signed) [illegible] M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL 11/8/1930

ADDRESS

UNDERTAKER Wm Cook 1217 St Paul St

Alberson Bill

r.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 62105
REGISTERED NO.

62105
1-PLACE OF DEATH

ity of Baltimore: (No. Mercy Hospital. St. 14-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore P. Schaefer.

(a) RESIDENCE NO. 230 E. Pleasant St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

6a If ~~XXXX~~ widowed, ~~XX XXXXXX~~ HUSBAND of ~~XXXXXXXX~~ Nettie Schaefer.

6 DATE OF BIRTH (month, day, and year) November 23, 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53	11	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER: John Schaefer

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Germany.

14 Informant: Nettie Schaefer. (daughter)
(Address) 2514 Loyola Southway.

15 [illegible] 1930 [illegible] ST. MARY'S, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) November 4, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 108 E. Franklin St.

Did an operation precede death? No. Date of Nov. 4, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.

11/6. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 11/8 1930

20 UNDERTAKER: William Cook

ADDRESS: 1219 Pulaski

...r.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62106

CERTIFICATE OF DEATH

662

REGISTERED NO. E 62106

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Lewis.(C)

(a) RESIDENCE NO. 1201 St.James St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residenre in city or town where death occurred 36 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	36	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Lewis.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Jane -------(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant (Address) Annie Morris.(C) 1501 Edmondson Ave.

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 4, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? St. James St. Nov. 4, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.

11/5. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL 11-7 1930

20 UNDERTAKER Dennis Eaton ADDRESS 916

LAGN

c—9-30—A. & Co.—250 Bks.

2107 HEALTH DEPARTMENT—CITY OF BALTIMORE 2107

CERTIFICATE OF DEATH.

86-001E

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE. (No. 936 N. Gilmor St. WARD) 6-22

2 FULL NAME Anna Nora Hicks

(a) RESIDENCE NO. 936 N. Gilmor ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) Oct 27-1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Essie McGuary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Essie Hicks
(Address) 936 N Gilmor St

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov. 4, 1930

that I last saw her alive on Nov 4, 1930

and that death occurred, on the date stated above, at 7-10 P.M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lemuel E. M. D.

19 (Address) 1303 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Nov 7 1930

20 UNDERTAKER Samuel Hensley

ADDRESS [illegible]

1-30—M. & T.—250 Bks.

E 62108 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-002 E 62108

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH 1200 Valley St.

CITY OF BALTIMORE: (NO. Little Sisters of the Poor ST.) 10-14 WARD)

2. FULL NAME Warren Marsh

(a) RESIDENCE NO. Preston + Valley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

8 BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER James Marsh

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Annie Garson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

Informant Little Sisters of the Poor
(Address) Preston + Valley St

Filed 7-1930 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov: 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/1, 1930, to 11/6, 1930, that I last saw h[illegible] alive on 11/6, 1930, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr Bernard Lowe, M. D.

11/7, 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 11/8 1930.

ADDRESS .....

20 UNDERTAKER Rita Wiedefeld 914 Fairmount Ave

1-30—M. & T.—250 Bks.

62109

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001 E 62109

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 752 W Lexington ST. 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A Browne

(a) RESIDENCE NO. 752 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 27 1855

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	2	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pennsylvania

10 NAME OF FATHER Edward A Browne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Kathryn M Browne

(Address) 752 W Lexington St

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5/30

17 I HEREBY CERTIFY, That I attended deceased from 11/4/ , 1930 , to 11/5/30 , 19 ,

that I last saw h— alive on 11/5/30 , 19 ,

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypotension

(duration) unkn yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) Bernard J. Fenn M. D.

11/6/1930 (Address) 910 W Lex mnt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bellefonte Penna.

DATE OF BURIAL Nov 10 1930

20 UNDERTAKER F Vernon Kechner

ADDRESS 153 Hollins

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62110

CERTIFICATE OF DEATH

16 2nd

REGISTERED NO. E 62110

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2330 Penna Av ST. 15-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Thomas

(a) RESIDENCE NO. 2330 Penna Av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 31, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	6	5

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto Md
(State or country)

10 NAME OF FATHER William Thomas

11 BIRTHPLACE OF FATHER (city or town) Athens
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Blanche Louis

13 BIRTHPLACE OF MOTHER (city or town) Cartersville
(State or country) Ga

Informant Mother

(Address)

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1930, to Nov. 6, 1930,

that I last saw him alive on Nov 6 1930

and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease of the newborn

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no Clinical findings

What test confirmed diagnosis?

(Signed) H. Alexander Bovey, M. D.

, 19 (Address) 15-16 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Nov 5 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1 E Eastman St

1-30—M. & T.—250 Bks.

E 62111 HEALTH DEPARTMENT—CITY OF BALTIMORE 54 E 62111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Provident Hosp. 1420

Y OF BALTIMORE: (No. 1514 Division St ST., 14 WARD)

2-FULL NAME Gertrude Virgie Ford Jones.

(a) RESIDENCE NO. 1420 Wilmer Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Widow

f married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) 1903

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Petersburg Virginia

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Calvin Mason

(Address) 1420 Wilmer St

Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25th, 1930, to Nov. 6th, 1930, that I last saw her alive on Nov. 6th, 1930, and that death occurred, on the date stated above, at 3 05 A. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Dr. George McDonald, M. D.

, 19 (Address) 200 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Nov 7 1930

20 UNDERTAKER Thomas. E. Kelson

ADDRESS 1303 Pressman St

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

62112

E 62112
60-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 431 N Gilmor ST. 19-27 WARD)

2-FULL NAME Mary J. Johnson

(a) RESIDENCE NO. 431 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married.

If married, widowed, or divorced (HUSBAND) of or) WIFE of Calvin Johnson Sr.

DATE OF BIRTH (month, day, and year) March 11- 1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	7	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER John Humphries

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Bragg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Calvin Johnson Sr

(Address) 431 N Gilmor St

FILED 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1930, to 11/5, 1930, that I last saw h[er] alive on 11/4, 1930, and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation and Chronic Parenchymatous Nephritis.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Generalized Anasarca and Toxic Uremia (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. J. Young, M. D.

11/6 1930 (Address) 429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Nov 9 1930

20 UNDERTAKER Sam W. Brashears

ADDRESS 400 Mosher

—1-30—M. & T.—250 Bks

E 62113

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-002

E 62113

CERTIFICATE OF DEATH.

REGISTERED NO. 15-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 3708 Reisterstown Rd ST. (WARD)

2-FULL NAME Baby Boy Kimbal

(a) RESIDENCE NO. 3708 Reisterstown Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced (HUSBAND) of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 29, 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	9 8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Jacob L Kimbal

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York N. Y.

12 MAIDEN NAME OF MOTHER Reba Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant (Address) J. Lewis 1434 E. Baltimore St

Filed T-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 7, 1930, that I last saw h[illegible] alive on Nov 7, 1930, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows: (Bantis disease)

Splenomegaly (duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin data

(Signed) J. Schlang M. D.

. 19 (Address) 3042 Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL 11-7-30

20 UNDERTAKER Jack Lewis, 1434 E Balto St

ADDRESS

—1-30—M. & T.—250 Bks

E 62114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62114

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

Y OF BALTIMORE: (No. 13-536 ST. WARD)

2-FULL NAME Isaiah Balderston

(a) RESIDENCE NO. 3540 Hickory Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

f married, widowed, or divorced (or) HUSBAND of (or) WIFE of Mary Balderston

ATE OF BIRTH (month, day, and year) March 2, 1865

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	8	3	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cotton mill worker

(b) General nature of industry, business, or establishment in which employed (or employer) 046

(c) Name of employer Woodberry Cotton Mills

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Glen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Buckingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of

(Address) Balto. City Hosp.

Filed 19 C. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5-30

17 I HEREBY CERTIFY, That I attended deceased from 9-26-30, 19 , to 11-5-30, 19 ,

that I last saw him alive on 11-5-30, 19 ,

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis general & cerebral

Myocarditis, chronic

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jas Glennon Jr. M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden

DATE OF BURIAL Nov 8, 1930

20 UNDERTAKER Thos. E. Love & Sons

ADDRESS 3615 Chestnut Ave

J 7 - 1930

C. [illegible] Registrar

Spec.—7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62115 ✓ E 62115

175

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4129 Falls Road St. 13-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Ann Domstadt

(a) RESIDENCE NO. 4129 Falls Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Nov. 13, 1929

7 AGE: Years — Months: 11 — Days: 23 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Ernest Domstadt

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Rachel A. Robbins

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Ernest Domstadt

(Address): 4129 Falls Road

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 6, 19 30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1930 to Nov. 6, 1930

that I last saw her alive on Nov. 5, 1930

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Gastritis, Botulism

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Carbon Failure

Toxemia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) Frank H. Martin, M. D.

, 19 (Address) 4103 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — Date of Burial: Nov 8 1930

20 UNDERTAKER: Thanhouser Son — ADDRESS: 36 E Lafayette Ave

1930

Douglas ✓ E 62116

L. & T.—100 B—50L

E 62116

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

(a) OF BALTIMORE: (No. St. Joseph Hospital ST. 27-47 WARD)

2-FULL NAME George W. Douglas

(b) RESIDENCE NO 4230 Ivanhoe Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

(c) Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ida G. Douglas

7 DATE OF BIRTH (month, day, and year) June 12/1871

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	4	25	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050
(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Balto., Md.

11 NAME OF FATHER James H. Douglas

12 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

13 MAIDEN NAME OF MOTHER Margaret Tuter

14 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

15 Informant Ida G. Douglas
(Address) 4230 Ivanhoe Ave

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Odema

..... (duration) ..... yrs. ..... mos ..... ds.

Probably Mitral Stenosis

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Joseph Carr, M. D.
Coroner

Nov 7, 19 30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Nov 19 30

20 UNDERTAKER Chenoweth Son

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62117 4th E 62117

CERTIFICATE OF DEATH.

REGISTERED NO. 76-42

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Cedella Ave. nr. Frankford Ave. (St.) (Ward) 26th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha A. Hoffstetter

(a) RESIDENCE NO. Cedella Ave., nr. Frankford Ave. ST., 26th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Hoffstetter

DATE OF BIRTH (month, day, and year) Sept. 13th, 1870

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	1	23	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore County, Maryland

PARENTS

10 NAME OF FATHER August Hofmeister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Margaret Milchling

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co. (State or country) Maryland

14 Informant William Hoffstetter. (Address) Cedella Ave. nr. Frankford Ave.

15 -1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1930 to November 6, 1930, that I last saw her alive on Nov. 5, 1930, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

(1)- Carcinoma of stomach lesser curvature, duration probably three or four years.

(2)- Diabetes Mellitus, duration at least two yrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage, duration 10 days. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Gross pathology of abdominal viscera.

(Signed) A. L. Wilkinson M. D.
A. L. Wilkinson,
11/7, 1930 (Address) 5713 Belair Rd., Raspeburg, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery Co. DATE OF BURIAL Nov. 10 1930

20 UNDERTAKER Fredk Lassahn Sons ADDRESS 7401 Belair Rd.

—1-30—M. & T.—250 Blks

62118 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62118

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 4312 Raspe Ave. Raspeburg ST., WARD

2-FULL NAME David B. Smythe

(a) RESIDENCE NO. 4312 Raspe Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced (HUSBAND of or) WIFE of Mary Smythe

DATE OF BIRTH (month, day, and year) Jan. 2nd 1865

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer) Coffee

(c) Name of employer J. W. Wagner Co.

BIRTHPLACE (city or town) (State or country) Unknown England

10 NAME OF FATHER William Smythe

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) England

12 MAIDEN NAME OF MOTHER Dorothy Blakeley

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) England

Informant Mary Smythe

(Address) 4312 Raspe Ave

Filed 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 1930 to Nov 5 1930

that I last saw him alive on Nov 5 1930

and that death occurred, on the date stated above, at 8:05 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart

Myocarditis. Acute

Broncho Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert G. Webster, M. D.

, 19 (Address) 6209 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Nov. 8 1930

20 UNDERTAKER Frederick Lassahn & Sons

ADDRESS 7401 Belair Rd.

—1-30—M. & T.—250 Bks.

070

E 62119

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62119

123

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-12 WARD)

2-FULL NAME Mary Shabela

(a) RESIDENCE NO. 717 N. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X: Female

4 COLOR OR RACE: White

5 [illegible], Married, Widowed, or Divorced (write the word): Widow

If married, widowed, or divorced: (a) HUSBAND of or (b) WIFE of James Shabela

ATE OF BIRTH (month, day, and year) [illegible]

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Did Side Maid

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Czecho-Slovakia

10 NAME OF FATHER: Jimmy Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Czecho-Slovakia

12 MAIDEN NAME OF MOTHER: Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Czecho-Slovakia

Informant: Family

(Address) JOHNS HOPKINS HOSPITAL

Filed 1930, 19 — HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6/30

17 I HEREBY CERTIFY, That I attended deceased from October 27, 1930 to November 6, 1930, that I last saw her alive on November 6, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pneumonia

6 days. (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pneumonia developed after operation for gall stones & chronic nephritis (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 11-1-30.

Was there an autopsy? no.

What test confirmed diagnosis? Operation confirmed Gall Stones x-Ray confirmed Pneumonia.

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill

DATE OF BURIAL: Nov. 9 1930

20 UNDERTAKER: Frank Brockton

ADDRESS: 406 N. Wonder

—1-30—M. & T.—250 Bks.

62120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-8

E 62120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 12-57 WARD

2-FULL NAME Mary Louise Coost

(a) RESIDENCE NO. 1421 Morling ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred — yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

If married, widowed, or divorced HUSBAND of or) WIFE of —

ATE OF BIRTH (month, day, and year) Feb-14-1930

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	8	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Herbert Coost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Pearl Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 1930 C. H. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-7-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-28, 1930, to Nov 7, 1930

that I last saw her alive on Nov 7, 1930,

and that death occurred, on the date stated above, at 2:10 A. m.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Pharyngitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes What test confirmed diagnosis? Physical Findings

(Signed) R. O. Watson, M. D.

11/7, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shrewsbury, Pa.

DATE OF BURIAL Nov. 9 1930

20 UNDERTAKER Horace H. Burgee

ADDRESS 3631 Falls Rd.

1-30—M. & T.—250 Blks.

41999
62121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 E 62121

REGISTERED NO.

1-PLACE OF DEATH
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME Charles Hicks

(a) RESIDENCE NO. 338 Beechwood Rd ST., WARD Sparrows Point Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 18-1930

AGE Years ~~Months~~ Days 19 If LESS than 1 day, hrs. or min.
5 weeks

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER Sam Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Kathleen Shuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: Records
(Address) JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.

Filed 1930 By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 7-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Nov 7, 1930, that I last saw him alive on Nov 7, 1930, and that death occurred, on the date stated above, at 6:2 a. m.

The CAUSE OF DEATH* was as follows:
Bacillary Dysentery

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of
Was there an autopsy? no Stool culture
What test confirmed diagnosis?

(Signed) [illegible], M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orange Va — DATE OF BURIAL: 11-8 1930

20 UNDERTAKER: Robert Brookdale — ADDRESS: Baltimore Md

—8-16-29—L. F. S.—100 Bks.

E 62122

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62122

CERTIFICATE OF DEATH

96

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No.) 2700 N. Charles ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Harris

(a) RESIDENCE NO. 2700 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

f married, widowed, or divorced HUSBAND of (or) WIFE of Susie Mullin 1859

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	71	—	—	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 63

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer —

IRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Robert Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Meade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Mrs Harris

(Address) 2700 N. Charles St

FILED 1930 G. RAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6/30

17

I HEREBY CERTIFY, That I attended deceased from January, 1930, to Nov 6, 1930, that I last saw him alive on Nov 6, 1930, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Emma Krieger, M. D.

11/6, 1930 (Address) Hickory Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Nov 8 1930

20 UNDERTAKER Mary M. Medford — ADDRESS 501 E 22nd St

—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62123

62123

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (NO. 2101 Boone ST., 9-11 WARD)

2-FULL NAME John F. Raabe

(a) RESIDENCE NO. 2101 Boone ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
race	White	Widower

married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Raabe

ATE OF BIRTH (month, day, and year) Jan 26 1842

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	9	11 10	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery man

(c) Name of employer

IRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER John Raabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Henry J. Raabe

(Address) 411 Edmondson Road

Filed 1930 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1930 to Nov 6th 1930.

that I last saw h alive on Nov 6th 1930.

and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Senile Complex of Age

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal

(Signed) Edward Schubert M. D.

Nov 7 1930 (Address) 9 N. 29th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Nov 8 1930

20 UNDERTAKER Wm. Jno. J. McGuire & Son

ADDRESS 211 N. Fayette

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

62124 E 62124

CERTIFICATE OF DEATH.

REGISTERED NO. 74-00 32

1-PLACE OF DEATH

(a) CITY OF BALTIMORE: (No.) 2420 Banger ST., WARD) 45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kaufman

(a) RESIDENCE NO. 2420 Banger ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced (write) HUSBAND of (or) WIFE of Esther Kaufman

7 DATE OF BIRTH (month, day, and year) Sept 15 1866

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Joseph Wittleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Esther Kaufman

(Address) 2420 Banger St.

Filed Nov 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 30

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930 to Nov 7, 1930, that I last saw her alive on Nov 6, 1930, and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) Nil yrs. Nil mos 7 ds.

CONTRIBUTORY (Secondary) Senile psychosis

(duration) Nil yrs. Nil mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Nil Date of

Was there an autopsy? Nil

What test confirmed diagnosis? Spinal tap

(Signed) Raymond C. Hiemenz, M. D.

Nov 7, 1930 (Address) 2308 Eutaw Pl Nov

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov. 10 1930

20 UNDERTAKER Mrs. Sam H. Perfect Inc

ADDRESS 701 W. Fayette St

1-30 M. & T.—250 Blks

62125

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62125

92

CERTIFICATE OF DEATH.

REGISTERED NO. 15263

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No. 3700 Rochester St. WARD)

2-FULL NAME Augusta Spear

(a) RESIDENCE NO. 3700 Rochester Road WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widow

married, widowed, or divorced
HUSBAND of
or) WIFE of Abraham Spear

ATE OF BIRTH (month, day, and year) Feb. 14, 1861

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	23	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Balto.
(State or country) Md.

10 NAME OF FATHER Leopold Lucks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Hillenburg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Mrs. J. Spear

(Address) 3700 Rochester Rd.

C. HAMPSON JONES, M. D.

Filed 19 By Registrar

-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13th, 1926, to November 7, 1930,

that I last saw h er alive on Nov. 6, 1930,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observations

(Signed) Eugene J. Cooper, M. D.

, 19 (Address) 200 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 11/9/1930

20 UNDERTAKER Harid Sondheim Son

ADDRESS 1902 Eutaw Place

—1-30—M. & T.—250 Blks.

62126 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62126

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH Baltimore City Hosp. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (No. 5-40 ST., WARD)

2-FULL NAME William B. Montgomery

(a) RESIDENCE NO. 2212 Toney's Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	White	Widowed.

married, widowed, or divorced HUSBAND) of or) WIFE of Ida ?

ATE OF BIRTH (month, day, and year) Dec 15, 1861

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
9				

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) ? 015

(c) Name of employer ?

IRTHPLACE (city or town) Frederick County (State or country) Md.

10 NAME OF FATHER Axel Montgomery

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriett Wallace ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Friend (Address) Baltimore City Hosp.

Filed 1930 C. HOWARD JONES, Registrar RKM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-30

17 I HEREBY CERTIFY, That I attended deceased from 10-10-, 1930, to 11-3-, 1930, that I last saw him alive on 11-3-, 1930, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Benign hypertrophy of prostate

(duration) mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Hosp.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Fred M. Buckheister, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	NOV 7 1930
20 UNDERTAKER	ADDRESS

1-30 M. & T. 250 Blks

E 62127

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62127

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 17-24 ST., WARD)

2-FULL NAME Charle Olden

3(a) RESIDENCE No. 810 Druid Hill Ave. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced
(or) HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal yard 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chesapeake Coal Co.

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER West Olden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Louise ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Records of

(Address) Balto. City Hosp.

FILED 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2-30

17 I HEREBY CERTIFY, That I attended deceased from 10-28-30, 19, to 11-2-30, 19,

that I last saw him alive on 11-2-30, 19,

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease, Rheumatic

(duration) UNKNOWN yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget. M. D.

11-5, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL NOV 7 1930

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health

—1-30—M. & T.—350 Blks

Dr Marr 516 Cathedral St Hum 1186

HEALTH DEPARTMENT—CITY OF BALTIMORE

62128 E 62128

CERTIFICATE OF DEATH.

REGISTERED NO. 32

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1323 Bethlehem Ave, ST., Edgewood Park WARD) 16-37

2-FULL NAME Brynley Harold Lott

(a) RESIDENCE NO. 1323 Bethlehem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced (or) HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 10/5/1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		1	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Brynley Lott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Bessie Seifert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Brynley Lott

(Address) 1323 Bethlehem Ave

Filed 1930 G. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6/1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1930, to Nov. 6, 1930, that I last saw h- alive on Nov. 6, 1930, and that death occurred, on the date stated above, at 9:20 A. m.

The CAUSE OF DEATH* was as follows:

I Tuberculosis Pneumonitis

(duration) yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. J. Marr, M. D.

11. 7 1930 (Address) 516 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 11/8/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul st

H. & T.—100 B—50L

62129

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62129

CERTIFICATE OF DEATH

88

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1. PLACE OF DEATH

(a) OF BALTIMORE: (No.) En route to University Hospital ST., (or) WARD

2. FULL NAME Frank W. Pullman

3. (a) RESIDENCE NO. 620 N. Payson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

(b) Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of Helen Doris Pullman

7 DATE OF BIRTH (month, day, and year) July 12-1897

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	3	24	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Straw-fitter
(b) General nature of industry, business, or establishment in which employed (or employer) 060
(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) N. C.

11 NAME OF FATHER Swan Pullman

12 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

13 MAIDEN NAME OF MOTHER Mary Cox

14 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

15 Informant Mrs. Nora Pullman (Address) 620 N. Payson St.

FILED 1930 [illegible], Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Feller, M. D. Coroner

11/7, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 11-10 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St. Paul St

1-30—M. & T.—250 Blks Dr Murgatroyd 401 E. 25th St Univ 1582

E 62130 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62130

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No. 1726 N. Durham ST. 8-17 WARD)

2-FULL NAME Rovina E Barnett

(a) RESIDENCE NO. 1726 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ William H Barnett

ATE OF BIRTH (month, day, and year) Sept 16th 1880

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	1	20	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

IRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Capt Henry C. Bullers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Legg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Wm H. Barnett

(Address) 1726 N. Durham

Filed 7-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24th 1930, to Nov 6th 1930, that I last saw ~~her~~ alive on Nov 5th 1930 and that death occurred, on the date stated above, at 7.10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Coma

(duration) yrs. mos 3 ds.

Apoplexy Coronary Atheroma Hypertension

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo Murgatroyd M.D.

10/7/1930 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 11/8/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62131 — CERTIFICATE OF DEATH — 44 E 62131

—PLACE OF DEATH — Morrell Park — REGISTERED NO.

Y OF BALTIMORE, (No. 2311 James ST., 25-72 WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME J. Albert Cornelius

a) RESIDENCE NO. 2311 James ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

th of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ M. Amelia Cornelius

ATE OF BIRTH (month, day, and year) Feb. 5 - 1871

LE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	9		

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 64

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto Co.

10 NAME OF FATHER John E. Cornelius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Rachel Belt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

Informant M. Amelia Cornelius

(Address) 2311 James St

Filed Nov 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 30

17 I HEREBY CERTIFY, That I attended deceased from James 1930, to Nov 5 1930, that I last saw h.. alive on Nov 5 1930 and that death occurred, on the date stated above, at 8-20 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 1926

Was there an autopsy? no

What test confirmed diagnosis? Aspiration + Roentgen and Pathological Sarcoma

(Signed) Geo M Kieffer, M. D.

Nov 5 1930 (Address) 2424 Hoch Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Nov 8 1930

20 UNDERTAKER A. S. Marshall — ADDRESS 3539 Falls Rd

ec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62132

E 62132

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: NO. Caton & Wilkens Ave ST. 27-30 WARD

2-FULL NAME David H. Vess

(a) RESIDENCE NO. 124 W Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 ½ yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Vess

7 DATE OF BIRTH (month, day, and year): Oct. 7, 1908

8 AGE: Years 22 Months 1 Days If LESS than 1 day, hrs or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Auto Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Asheville, N.C.

PARENTS

10 NAME OF FATHER: Robert A. Vess

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Carrie Frady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant: Helen Vess (Address): 124 W Lee St

15 C. HARRISON JONES, M. D. Registrar

7-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-7 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-4 1930 to 11-7 1930

that I last saw him alive on 11-7 1930

and that death occurred, on the date stated above, at 10 15 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar Bilateral

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis (duration) yrs. mos. 10 ds.

Toxemia

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Hjalmar S Anderson M. D.

11/7 1930 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Nov. 10 1930

20 UNDERTAKER: Lapell Cook

ADDRESS: 1003 West Baltimore St

—M. & T.—100 B—50L

E 62133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62133

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1826 Westwood ST. 15-21 (WARD)

2-FULL NAME Linnatus Major.

(a) RESIDENCE NO. 1826 Westwood ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

If married, widowed, or divorced HUSBAND) of (or) WIFE of Emma Major

DATE OF BIRTH (month, day, and year) Apl 13-1892

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	6	23	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Theatre Manager
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Allen Major

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Timothy West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Major (Address) 1826 Westwood

15 Filed NOV 5 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Indigestion

CONTRIBUTORY (Secondary) Error of diet (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) C. Hampson Jones Coroner, M. D.

19 30 (Address) Govans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 11 8 1930

UNDERTAKER Samuel J. Beverley

ADDRESS 576 W. Baltimore

1-30—M. & T.—250 Bks.

E 62134 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62134

CERTIFICATE OF DEATH.

117

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) South Balt Gen Hospital ST., (WARD)

2-FULL NAME Mrs George MORRIS Della

(a) RESIDENCE NO. 3211 Gibbons ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 42 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single

If married, widowed, or divorced
(h) HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 4 1888

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	5	2	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) crippled boy
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John Della

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Hospital Records
(Address)

Filed -1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov-6, 1930, that I last saw h[im] alive on Nov. 6, 1930, and that death occurred, on the date stated above, at 740 P m.

The CAUSE OF DEATH* was as follows:
Acute perforated appendicitis
Acute general Peritonitis
(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3211 Gibbons ave
Did an operation precede death? Yes Date of Oct. 30-1930
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Wm. J. Sullivan, M. D.
, 19 (Address) So Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery
DATE OF BURIAL Nov 11 1930

20 UNDERTAKER John F. Denny
ADDRESS John F. Denny

2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62135

CERTIFICATE OF DEATH

91-002 E 62135

REGISTERED NO.

—PLACE OF DEATH

Y OF BALTIMORE: (No. 105 E. Cross ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Henry Bell Bowen

(b) RESIDENCE NO. 105 E. Cross ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
2le	White	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of Martha Bowen

TE OF BIRTH (month, day, and year) Oct. 26, 1847

E. Years	Months	Days	If LESS than 1 day, hrs or min.
83	0	11	

CUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) Salisbury, Md.
State or country)

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

Informant Jesse W. Bowen

(Address) 105 E. Cross St.

Filed 1930 By: C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1930, to Nov 6-th, 1930, that I last saw him alive on Nov 5 th, 1930 and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted? If not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. C. Bryden, M. D.

11/4, 1930 (Address) 301 E. Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 9 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

—M. & T.—100 B—50L

Lillian Terrell

101-001

E 62136

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62136

CERTIFICATE OF DEATH

REGISTERED NO. E 62136

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) Hopkins Hospital ST. 5 WARD 9

2-FULL NAME Lillian Terrell

(a) RESIDENCE NO 201 N. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) May 10/30

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	28	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Samuel Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Marie Terrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Marie Terrell
(Address) 201 Spring St

15 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia
Purulent Cerebral Meningitis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) J. S. H. Bruen, Coroner, M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary cemetery

DATE OF BURIAL nov 8 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

1-30—M. & T.—250 Bks.

62137

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 E 62137

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No. St Paul Cpt St Paul & W Royal Ave ST. WARD)

-FULL NAME Margaret Cottman Boyle

(a) RESIDENCE NO. St Paul Cpt St Paul & W Royal Ave ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
	White	Widow

married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of James Boyle

ATE OF BIRTH (month, day, and year) Unknown

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	82			

CCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Jas Stewart Cottman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Boggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs. Wassington Cottman

(Address) St Paul Cpt

Filed 11-8-1930 C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 3rd, 19 30, to Nov 7th, 19 30,

that I last saw h. alive on Nov 4th, 19 30,

and that death occurred, on the date stated above, at 1 1 a. m.

The CAUSE OF DEATH* was as follows:-

Cerebral Hemorrhage

(duration) ....yrs. ....mos 3 ....ds.

CONTRIBUTORY (Secondary) Senility

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Simmons M. D.

11-8, 19 30 (Address) 2603 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Nov 8 1930
20 UNDERTAKER Henry H Jenkins Sons Co	ADDRESS Orchard & Gay Sts

-1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE E 62138

62138

CERTIFICATE OF DEATH.

REGISTERED NO. 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1.-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Foster Ave. ST. 26-37 WARD)

2.-FULL NAME Anna S. Aires

(a) RESIDENCE NO. 3710 Foster Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (or) WIFE of HUSBAND of James M. Aires

6 DATE OF BIRTH (month, day, and year) Aug. 14 1861

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	2	22	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Penna.

10 NAME OF FATHER John Kauffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Eliz. Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

Informant James M. Aires

(Address) 3710 Foster Ave.

FILED 1930 No. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to Nov 5, 1930, that I last saw h[illegible] alive on Nov 5, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carl Schneider M. D.

11/6. 1930 (Address) 2934 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov. 10 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 737 E. Eager St

-1-30—M. & T.—250 Bks

E 62139

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62139

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

Y OF BALTIMORE: (NO. 911 W. Fayette ST. 18-26 (WARD)

-FULL NAME Mattie Winn

(a) RESIDENCE NO. 911 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 16 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	Single

married, widowed, or divorced
HUSBAND) of
or) WIFE of —

ATE OF BIRTH (month, day, and year) March 11, 1914

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	7	26	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student HS

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) Baltimore
(State or country) Md

10 NAME OF FATHER William Winn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Beatrice Robinson

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Va

Informant Beatrice Robinson
(Address) 911 W. Fayette St.

Filed ... 19 C. HAMPSON JONES, M. D.
Registrar
2 - 1930 By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 5, 1930, that I last saw her alive on Nov 5, 1930, and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) ....yrs. ....mos 2 da.

CONTRIBUTORY (Secondary) Rupture of Appendix

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Macco Williams, M. D.

Nov 6 1930 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Nov. 8, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3214 Schroeder St.

1-30 M. & T.—250 Bks.

E 62140 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62140

CERTIFICATE OF DEATH.

159

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) 1004 Aisquith ST. 10-14 (WARD)

2-FULL NAME Joseph Herbert

(a) RESIDENCE NO. 1004 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Sing.

married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Nov. 6 1930

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Joseph A. Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Schmeisser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Mr. Joseph A. Herbert

(Address) 1004 Aisquith St

Filed NOV 6 - 1930 Per E. T. [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1930

17 I HEREBY CERTIFY, That I attended deceased from North 5th, 1930, to Nov 6th, 1930, that I last saw him alive on Nov 6th, 1930, and that death occurred, on the date stated above, at 1.32 a.m.

The CAUSE OF DEATH* was as follows:

Non closure Foramen Ovale

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm H Yoner, M. D.

Nov 8, 1930 (Address) 4900 Belair Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

20 UNDERTAKER Henry Hoen Funeral

DATE OF BURIAL Nov. 8 1930

ADDRESS 1301 E Eager St

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62141 E 62141

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH Sr Agnes Hospital

Y OF BALTIMORE: (No.) 6 Caton Ave ST., 26-40 WARD)

-FULL NAME Mary J. Keagle

(a) RESIDENCE NO. 3055 Maybud ave WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widow

married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine Charles Keagle

ATE OF BIRTH (month, day, and year) May 6 1855

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	6	1	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Philadelphia Pa

10 NAME OF FATHER M. Volk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Mrs Irene E. Keagle

(Address) 3055 Maybud ave

Filed 11-8-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1-30

17 I HEREBY CERTIFY, That I attended deceased from 11-2-30, 19..., to 11-7-30, 19...,

that I last saw h alive on 11-7-30, 19... at 1.30 P m.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene Right foot - Myocarditis - Arterio Sclerosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism and Abscess (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11-5-30

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W B Blandford M. D.

Nov 7, 1930 (Address) Sr Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

UNDERTAKER Henry Hock & Sons Inc.

DATE OF BURIAL 11-11-1930

ADDRESS 501 E Eager St

1-30—M. & T.—250 Bks.

62142 HEALTH DEPARTMENT—CITY OF BALTIMORE VE 62142

113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Memorial Hospital

Y OF BALTIMORE: (No. 33rd + Calvert ST., 9-46 WARD)

2-FULL NAME Margaret Ward

(a) RESIDENCE NO. 943 Montpelier Ave ST., Baltimore WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 1 yrs. 0 mos. 4 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

married, widowed, or divorced HUSBAND of or) WIFE of —

ATE OF BIRTH (month, day, and year) Nov. 2, 1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	0	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (none)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER James S Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Oldham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records

(Address)

C. HAMPTON JONES, M. D.

Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1930

17 I HEREBY CERTIFY, That I attended deceased from October 24, 1930, to November 6, 1930,

that I last saw h.. alive on November 6, 1930,

and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia-Lobar

(duration) 0 yrs. 0 mos 16 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 0 yrs. 0 mos. ? ds.

18 Where was disease contracted if not at place of death? 943 Montpelier Ave. Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory + Clinical Findings

(Signed) Jesse S. Lewis, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore.

DATE OF BURIAL 11/8 1930

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans St

.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62143

CERTIFICATE OF DEATH

101-007

E 62143

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

ty of Baltimore: (No. Mercy Hospital. St. 22-31 Ward)

2-FULL NAME John Wing.(C)

(a) RESIDENCE NO. 700 S.Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ---mos.---ds.- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

7 DATE OF BIRTH (month, day, and year) Do not know.

8 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. old
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Morris Brown.(C)
(Address) 108 N.Montgomery St.

15 Filed ..... 193.. C. HAMPSON JONES, M. D. Registrar

1930 Pat. ACR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Pratt & South Sts. Nov. 3, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Otto Reinhardt M. D.

11/7, 1930 (Address) 1017 S.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct

DATE OF BURIAL Nov 7 1930

20 UNDERTAKER S. E. Brown's Son

ADDRESS Norwood

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62144 — CERTIFICATE OF DEATH — E 62144

REGISTERED NO. 95-15

—PLACE OF DEATH

Y OF BALTIMORE; (No. 601 Jeffery ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Daniel W. Blankmanship

(a) RESIDENCE NO. 601 Jeffery ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

rth of residence in city or town where death occurred 64 yrs. 7 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Louise Blankmanship

ATE OF BIRTH (month, day, and year) Mar 16-1866

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	20	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Eng.

(b) General nature of industry, business, or establishment in which employed (or employer) 20 Yrs

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Dan'l Blankmanship

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs. Blankmanship

(Address) 1431 Henry

Filed 1930 By G. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1930

17 I HEREBY CERTIFY That I attended deceased from Sept. 18, 1930, to Nov. 6, 1930; that I last saw h/M alive on Nov. 6, 1930, and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) K. P. Campbell M. D.

11/7, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL 11/10 1930

20 UNDERTAKER E. F. McCully

ADDRESS 130 E Fay

8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62145

CERTIFICATE OF DEATH

90 VE 62145

REGISTERED NO.

—PLACE OF DEATH

Y OF BALTIMORE: (No. 1841 Hanover St. ST. 23-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Rebecca A. Deckman

a) RESIDENCE NO. 1841 Hanover St. ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widow

married, widowed, or divorced
HUSBAND of (or) WIFE of Jacob Deckman

ATE OF BIRTH (month, day, and year) Mar. 31 1856

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	7	

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work None (W)

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

IRTHPLACE (city or town) Chester Co. Pa.
(State or country)

10 NAME OF FATHER Coleman Hooper

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Mr. Deckman
(Address) 1841 Hanover St.

Filed 1930 C. HAMPSON JONES, M. D., 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17 1930 to Nov. 8 1930.

that I last saw her alive on Nov. 8 1930

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Indefinite
(duration) yrs. mos. ds.

Exhaustion

CONTRIBUTORY (Secondary) (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. R. Campbell M. D.

11/8 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baker Cem Harford Co Md.

DATE OF BURIAL 11/11 1930

20 UNDERTAKER J. T. McCully

ADDRESS 130 E. Fort.

2-29-28—L. F. S.—500 Bks.

E 62146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 VE 62146

REGISTERED NO.

—PLACE OF DEATH

Y OF BALTIMORE: (No. 117 N Payson ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Clarence L Hill

a) RESIDENCE NO. 117 N Payson ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

rth of residence in city or town where death occurred 63 yrs. 6 mos. 22 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of Julia Rumsey

ATE OF BIRTH (month, day, and year) April 14-1866

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	6	22	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Register of Wills

(c) Name of employer Baltimore City

IRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Thomas Jefferson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Reed

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

Informant Miss L. F. Hill

(Address) 117 N. Payson St.

8- 1930 19 C. HARRISON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5-30

17 I HEREBY CERTIFY, That I attended deceased from January 30, 19 ... to Nov 5, 19 30.

that I last saw h alive on Nov 5, 19 30

and that death occurred, on the date stated above, at 2.40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Barry O'Meara, M. D.

Nov 6, 19 30 (Address) 600 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park Cemetery

DATE OF BURIAL Nov 8 19 30

20 UNDERTAKER F. R. Shepherd

ADDRESS 150 N. Balto St

2-29-28—L. F. S.—500 Bks.

E 62147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 62147

REGISTERED NO.

1—PLACE OF DEATH
(a) CITY OF BALTIMORE: (No. 746 ST. 11-6-30 WARD)
(b) FULL NAME Edw. St. Woods
(c) RESIDENCE NO. 746 N Fulton ave ST. WARD
(Usual place of abode)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
(If non-resident give city or town and State)
How long in U. S., if foreign birth? yrs. mos. ds.
(Length of residence in city or town where death occurred) 79 yrs. 9 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

married, widowed, or divorced
HUSBAND of (or) WIFE of Fanny Woods

6 DATE OF BIRTH (month, day, and year) Jan 13-51

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	27 10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Geo Bardeyle

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER W m M. Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Pa

12 MAIDEN NAME OF MOTHER Emma Barger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Mrs. B Woods Brother 746 N. Fulton ave
(Address)

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th 30

17 I HEREBY CERTIFY That I attended deceased from Oct 23 1930, to Nov 5th 1930, that I last saw h alive on Nov 5th 1930 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
Chronic Nephritis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia. Asthma
(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Benj O McCurry, M. D.
11/6 1930 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park.
DATE OF BURIAL Nov 8th 1930
20 UNDERTAKER J. B. Wappler & Son
ADDRESS 1853 W. Balto St

M. & T.—100 B—50L

E 62148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

VE 62148

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 99 WARD)

2-FULL NAME Esther M. Johnson

(a) RESIDENCE NO Myrth Ave, Essex, Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. / ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) May 2/29

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	5	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Essex, Md

10 NAME OF FATHER Herbert Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Myrtle Remmy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md

14 Informant Herbert Johnson
(Address) Essex, Md.

15 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough ..... (duration) ..... yrs. ..... mos ..... ds.

Secondary Bronchopneumonia ..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [illegible] Coroner, M. D.

Nov 18/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.

DATE OF BURIAL Nov. 20 1930

20 UNDERTAKER John J. Connelly

ADDRESS Essex

8-16-29—L. F. S.—100 Bks.

62149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62149

REGISTERED NO. 25-32

—PLACE OF DEATH

Y OF BALTIMORE: (No. 2825 Indiana Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Lucy L. Dantoni

) RESIDENCE NO. 2825 Indiana Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Dantoni

TE OF BIRTH (month, day, and year) Aug. 10 1865

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	27	

CUPATION OF DECEASED

) Trade, profession or articular kind of work Housework

b) General nature of industry, usiness, or establishment in hich employed (or employer) 0

c) Name of employer

IRTHPLACE (city or town) State or country) Italy

0 NAME OF FATHER Dominick Poligardo

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Mrs. John McMahon

(Address) 2825 Indiana Ave

-1930 C. Harrison Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-7-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1930, to Nov 7, 1930.

that I last saw h[illegible] alive on Nov. 1, 1930

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Hemiplegia

(duration) yrs. mos. 1 day

CONTRIBUTORY (Secondary) Senile Psychosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Harlan Rice, M. D.

11/8 1930 (Address) 6 Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 11/10 1930

20 UNDERTAKER L. F. McCully

ADDRESS 130 E Fort

-1-30—M. & T.—250 Bks

E. 62150

62150 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E [redacted]

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) 790 x Ireland Ave ST. 27-44 WARD

2-FULL NAME Julia Hill Karfgin

(a) RESIDENCE NO. 790 x Ireland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
[illegible]	White	Married

married, widowed or divorced
~~HUSBAND OF~~ or) WIFE of John H. Karfgin

ATE OF BIRTH (month, day, and year) July 29 1904

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	3	9	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

IRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Charles T. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mabel Bright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant John H. Karfgin

(Address) 790 x Ireland Ave

Filed [illegible] 1930 C. HAYDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7-1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to Nov 7, 1930, that I last saw h[illegible] alive on Nov 7, 1930, and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Exhaustion x Toxaemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Carl Smith M. D.

Nov 8 1930 (Address) 4708 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Nov 10 1930

UNDERTAKER J. J. Dickner & Sons

ADDRESS Lafayette

E 62151

1-30—M. & T.—250 Bks.

2157

62151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 [redacted]

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

a) OF BALTIMORE: (No. Lyden Hospital ST., 7-9 (WARD)

b) Nathaniel Brice

2-FULL NAME

a) RESIDENCE NO. 607 No. Bond ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

gth of residence in city or town where death occurred 7 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15, 1922

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	11	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Arthur Brice

11 BIRTHPLACE OF FATHER (city or town) (State or country) No. Carolina

12 MAIDEN NAME OF MOTHER Virginia Caldwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) No. Carolina

Informant Mrs. Virginia Brice

(Address) 607 No. Bond St.

FILED 11-9-1930 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1930, to Nov 7, 1930, that I last saw him alive on Nov 7, 1930, and that death occurred, on the date stated above, at 2 40 p. m.

The CAUSE OF DEATH* was as follows:

Nasal and Faucial Diphtheria

(duration) 0 yrs. 0 mos 10 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? 607 No. Bond St

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Nasal & Throat Cultures

(Signed) J. Peter Mezansky, M. D.

, 19 (Address) Lyden Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 11-9-1930

ADDRESS

20 UNDERTAKER Wm. H. Skinner 1620 E. Madison

1-30—M. & T.—250 Bks.

42297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62152

62152

62152

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

FULL NAME Anna Kreisel

(a) RESIDENCE NO. Stemmers Run Phil^a Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	married

married, widowed, or divorced (or) HUSBAND of (or) WIFE of Frederick

6 DATE OF BIRTH (month, day, and year) Feb 29 1882

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	8	9	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Md

9 NAME OF FATHER Wm Houseye

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Brandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Records

Address 1930 HOPKINS HOSPITAL

Filed 1930 19 BY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-8-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 1930 to Nov 8 1930

that I last saw her alive on Nov 8 1930

and that death occurred, on the date stated above, at 6 35 pm.

The CAUSE OF DEATH* was as follows:

Brain Tumor - not malignant
Cerebral Encephalitis

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) none (duration) ....yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 11-5-30

Was there an autopsy? yes

What test confirmed diagnosis? Path

(Signed) Fred'k Klein M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stemmers Run

DATE OF BURIAL 11/12/30 19

20 UNDERTAKER Frederick Lassahn & Son

ADDRESS 7401 Belair Rd

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62153 43 E 62153

REGISTERED NO.

—PLACE OF DEATH

Y OF BALTIMORE: (No. 27 S. Exeter ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Borsch Rudich

a) RESIDENCE NO. 27 S Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Bertha

TE OF BIRTH (month, day, and year) 1869

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

CUPATION OF DECEASED

a) Trade, profession or particular kind of work Presser

b) General nature of industry, business, or establishment in which employed (or employer) Co

c) Name of employer

RTHPLACE (city or town) (State or country) Austria

0 NAME OF FATHER Isaac Rudich

1 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

2 MAIDEN NAME OF MOTHER Rebecca —

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

Informant Bertha Rudich

(Address) 27 S. Exeter st

Filed 6 NOV [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7/30

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to Nov. 7th, 1930

that I last saw h alive on Nov. 5th, 1930

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of tongue.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Hunter, M. D.

11/8, 1930 (Address) 2735 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL Nov. 9 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1117 E Balto st

1-30—M. & T.—250 Bks.

E 62154 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 90 E 62154

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No. 1223 N. Linwood Ave ST., 8 WARD)

2-FULL NAME Joseph C. Krug.

(a) RESIDENCE NO. 1233 N Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, widowed, or divorced
HUSBAND of
or) WIFE of Arnetta Krug.

ATE OF BIRTH (month, day, and year) Oct 22-1855

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	✓	17	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Chas Krug

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

Informant Arnetta Krug

(Address) 1223 N Linwood Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1930, to Nov. 8, 1930,

that I last saw h~~e~~ alive on Nov. 7, 1930,

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Edema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schmidt M. D.

Nov 8, 1930 (Address) 701 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov 10 1930

20 UNDERTAKER Geo M. Smith & Son — ADDRESS 811 N Wolfe

CAON

—10-10-29—A Co.—100 Bks.

62155

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62155

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 5712 Grunmond Av St. 27-48 (Ward)

2-FULL NAME James A Fry

(a) RESIDENCE NO. 420 Howard Terrace St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Fry

7 DATE OF BIRTH (month, day, and year) 1873

8 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57			

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Virginia

PARENTS

10 NAME OF FATHER James Fry

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant Celia Fry Spouse
(Address) 420 Howard Terrace

Filed 9 1930 19 H. MASON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Heart

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm H Morrison, M. D.

11/8 1930 (Address) 1632 Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md — DATE OF BURIAL Nov 9 1930

20 UNDERTAKER Samuel Dewsley — ADDRESS 5784 N Biddle

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62156

62156

CERTIFICATE OF DEATH.

REGISTERED NO. 70

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) Lydenham Hospital ST. 14-20 WARD)

2-FULL NAME Betty Hall

3a) RESIDENCE NO. 1718 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	widowed

married, widowed, or divorced HUSBAND of (or) WIFE of Dandy Hall

6 DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) not employed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Arthur Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Timothy Hall

(Address) 1718 McCulloh St

Filed 1930, 19.. POLK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 7, 1930,

that I last saw h e alive on Nov 7, 1930,

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Abcess of Brain - Left Frontal Lobe

(duration) 0 yrs. 0 mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1718 McCulloh St

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) L. Peter Mehnert M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL White Stone Lancaster Co Va

DATE OF BURIAL Nov 9 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Freestman St

1-30—M. & T.—250 Blks.

62157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. A 62157

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

a) OF BALTIMORE: (NO. Baltimore City Hospitals WARD) ST. 8-12

b) FULL NAME Louis Leitznagle

c) RESIDENCE NO. 2400 Black E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

d) Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

4 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

16 DATE OF DEATH (month, day, and year) 11-7-30

6 If married, widowed, or divorced

HUSBAND of (or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from 12-16, 1907, to 11-7, 1930

that I last saw him alive on 11-7, 1930

and that death occurred, on the date stated above, at 12.45 P. m.

7 DATE OF BIRTH (month, day, and year)

The CAUSE OF DEATH* was as follows:

Years	Months	Days	If LESS than 1 day, hrs. or min.
61			

Cerebral Hemorrhage

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY (Secondary) Psychosis — Manic Depressive (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown Date of

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

9 BIRTHPLACE (City or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

(Signed) Nina Fort Smith, M. D.

11/1, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Informant (Address) Records City Hospitals

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 11/10 1930

20 UNDERTAKER William Cook

ADDRESS 1217 E. Pratt St

Filed 19 1930 CHARLES JONES, M. D. Registrar

1-30—M. & T.—250 Bks

Dr. Bubert 4754 Park Heights Ave
Liberty 6430 ✓
6 to 7:30 P.M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62158 — E 62158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 4933 Dennora Ave WARD) 27-56

2. FULL NAME Mary Lambert

3. (a) RESIDENCE NO. 4933 Dennora Ave WARD
(Usual place of abode) (If non-resident give city or town and State)
(b) Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

married, widowed, or divorced
(If) HUSBAND of
(or) WIFE of Thomas Lambert

6 DATE OF BIRTH (month, day, and year) 10/27/59

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	0	11	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ———
(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Georges Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Conrad T. Lambert
(Address) 4933 Dennora Ave

Filed 1930 HARRISON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/30

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1930 to Nov 8, 1930
that I last saw her alive on Nov 8, 1930
and that death occurred, on the date stated above, at 9.15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

1
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John D. Bubert, M. D.
(Address) 4754 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 11/12/1930

20 UNDERTAKER Wm Cook 1217 E Pratt St — ADDRESS

1-30—M. & T.—250 Bks

Dr Bagley 17 E Eager st. Pat. 1724 Pat. 1580

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62159

E 62159

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) 3029 Abell Ave (ST.) 17-50 (WARD)

2-FULL NAME Isaac Carey Downing

(a) RESIDENCE NO. 3029 Abell Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, ~~widowed~~, or divorced
HUSBAND of ~~or WIFE of~~ Emma P Downing

ATE OF BIRTH (month, day, and year) Dec 28th 1878

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	10	9	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md Lithograph Co

IRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER William F. Downing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Orlia Inright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant (Address) Mrs Emma P. Downing 3029 Abell Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 2 1929 to Nov 7 1930,

that I last saw h alive on Nov 1 1930,

and that death occurred, on the date stated above, at 2:25 m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of the brain

(duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of Oct 30 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A.M.L. Mitchell, M. D.

11 9, 1930 (Address) 711 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 11/10/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

C. HAMPSON JONES, M. D.

1-30—M. & T.—250 Blks

✓ E62160

2160

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 62160

CERTIFICATE OF DEATH.

62160

REGISTERED NO._____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
(a) CITY OF BALTIMORE: (No.) 46 N. Bentalou ST. 20-69 WARD)
2. FULL NAME John Alexander Hill
(a) RESIDENCE NO. 46 N. Bentalou ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced
HUSBAND of or WIFE of the late Catherine Love Hill

7 DATE OF BIRTH (month, day, and year) June 22 1851

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 093
(b) General nature of industry, business, or establishment in which employed (or employer) Messenger
(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

Informant Harry A. Hill
(Address) 46 N. Bentalou

Filed 1930 C. HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930, to Nov 7, 1930, that I last saw him alive on Nov 7, 1930, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:
Metastatic Carcinoma Sigmoid, Secondary to Carcinoma Prostate
(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arthritis (duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj O. McCurry, M. D.
11/8/30 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 11/11/1930

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson Ave

2-29-28—L. F. S.—500 Bks.

Henry L Kuhlemann

2161

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62161

CERTIFICATE OF DEATH

REGISTERED NO. 24006

—PLACE OF DEATH

Y OF BALTIMORE: (No.) 4801 Laurel ave ST., 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Henry L. Kuhlemann

) RESIDENCE NO. 4801 Laurel ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

h of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of Ella Kuhlema

TE OF BIRTH (month, day, and y) June 30 1852

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
8	4	7	

CUPATION OF DECEASED

) Trade, profession or particular kind of work Nurse Retired

) General nature of industry, siness, or establishment in hich employed (or employer) Nursing Institute & egg farm

) Name of employer

RTHPLACE (city or town) Baltimore
State or country)

0 NAME OF FATHER Chas F Kuhlemann

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

2 MAIDEN NAME OF MOTHER Sozzeld Wagner

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Ella H. Kuhlemann

(Address) 4801 Laurel Ave

Filed Nov 8, 1930 H. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Nov 6, 1930, that I last saw h alive on Nov 6, 1930 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) 2 yrs. mos. ds.

Hemiplegia

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Oram, M. D.

(Address) 612 N 40 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Violetville Md — DATE OF BURIAL 11/9/1930

20 UNDERTAKER Geo. Kelly & Son — ADDRESS 2503 Edmondson

H. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓

E 62162

2162

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

OF BALTIMORE: (No. 940 W. Lexington ST. 18-76 (WARD)

FULL NAME Bessie White (Whiting)

) RESIDENCE NO 940 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

married, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year) April 5-1895

E	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	7	2	

CUPATION OF DECESED
) Trade, profession or particular kind of work: Housework
) General nature of industry, business, or establishment in which employed (or employer)
) Name of employer

RTHPLACE (city or town) (State or country): Md.

0 NAME OF FATHER Jervis White

1 BIRTHPLACE OF FATHER (city or town) (State or country): Md

2 MAIDEN NAME OF MOTHER Bessie White

3 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

nformant: James White

(Address) 940 W. Lexington St

Filed ..... 192 ..... JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Haemoptysis - probably due to Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feldt, CORONER, M. D.

11/8, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL 11/10 1930

20 UNDERTAKER Emmert Gallagher

ADDRESS 2018 Carrollton Ave

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 62163

CERTIFICATE OF DEATH

E 62163

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—PLACE OF DEATH

Y OF BALTIMORE: (No. 213 N Patterson Pk ST., 6-10 WARD)

—FULL NAME Edward L. Skirvan

a) RESIDENCE NO. 213 N. Patterson Park ST., WARD

(Usual place of abode)

th of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of —

TE OF BIRTH (month, day, and year) Jan 27 1892

E	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	1	11	

CUPATION OF DECEASED

a) Trade, profession or particular kind of work Salesman

b) General nature of industry, business, or establishment in which employed (or employer) Clothing 466

c) Name of employer

RTHPLACE (city or town) (State or country) Balto

0 NAME OF FATHER Gustav Skirvan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lucas Hatter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Gustav Skirvan

(Address) 213 N Patterson Pk

FI[illegible] 19[illegible] H. E. JONES, M. D. Registrar

9 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1930 to Nov 8 1930

that I last saw h[illegible] alive on Nov 7 1930

and that death occurred, on the date stated above, at 3 7 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter Voight, M. D.

19 (Address) 46 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov. 10 1930

20 UNDERTAKER Frank Brockman

ADDRESS 1906 Aliceanna

1-30—M. & T.—250 Bks.

2250
Lung.
E 62164

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62164

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-9 WARD)

FULL NAME Leonard Bailey

(a) RESIDENCE NO. 343 Hamilton Ave. ST., Norfolk Va. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	not single

married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
76			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Vermont

10 NAME OF FATHER F. C. Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont

Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed NOV 5 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 4, 1930,
that I last saw him alive on Nov 4, 1930,
and that death occurred, on the date stated above, at 5 05 P. m.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction
tumor ?
(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) pneumonia, bronchial
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Philadelphia
Did an operation precede death? yes Date of 11-4-30
Was there an autopsy? yes
What test confirmed diagnosis? Gross observation

(Signed) I. K. Trimble, M. D.
Nov 8 1930 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northwestern Cemetery — DATE OF BURIAL Nov 6 1930

20 UNDERTAKER Geo. O. Weaver & Sons — ADDRESS Pikesville

2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62165 129 E 62165

62165

1 PLACE OF DEATH
(a) CITY OF BALTIMORE (No. 48 East Hennetta 2nd WARD)

2 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

3 FULL NAME John Ferguson

(b) RESIDENCE NO. 48 East Hennetta St WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3 - 1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	—	5	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

8 BIRTHPLACE (city or town) Mass
(State or country) Falls River

10 NAME OF FATHER Jas Ferguson

11 BIRTHPLACE OF FATHER (city or town) Mass
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Mass
(State or country)

Informant N. Backhens
(Address) 48 E. Hennetta St

Filed 9-1930, 19 PK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1930.

17 I HEREBY CERTIFY, That I attended deceased from 9.15.30, 19 to Nov. 8, 19 30
that I last saw h[illegible] live on Nov. 7, 19 30
and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam.

(Signed) J. Edward Norris M. D.
11.8, 19 30 (Address) 107 East west St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wm Oliver
DATE OF BURIAL 11/10/30 19
ADDRESS [illegible] Fremont Ave

20 UNDERTAKER Geo Lembach

10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62166

CERTIFICATE OF DEATH

129 E 62166

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

y of Baltimore: (No. 1511 Guilford Ave. St. 12-50 (Ward)

2-FULL NAME Jacob H White.

(a) RESIDENCE NO. 2623 Barclay St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

If married, HUSBAND of Laura White.

DATE OF BIRTH (month, day, and year) May 25, 1877

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	5	12/11	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer): C30
(c) Name of employer

BIRTHPLACE (city or town): Balto. Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER: George White.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Lydia Swan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md.

14 Informant: John M. White. (brother)
(Address) 3549 Keswick Rd.

15 Filed 9-1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 6, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertrophy and dilatation of the Heart Coronary Sclerosis, General Cortic Sclerosis, Odema and congestion of the Lungs, Chronic Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry

(Signed) [illegible] M. D.

11/7, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood — DATE OF BURIAL: Nov. 10-1930

20 UNDERTAKER: Horace F. Burgee — ADDRESS: 3631 Falls Road

1-30—M. & T.—250 Blks.

62167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001 E 62167

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Memorial Hospital ST. 9-47 WARD)

OF BALTIMORE: (NO.

2-FULL NAME James R Thomas

3) RESIDENCE NO. 702 E. Melville Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

married, widowed, or divorced HUSBAND of or) WIFE of Katherine L. J Thomas

ATE OF BIRTH (month, day, and year) Sept 25th 1882

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48	11	13	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 078

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways.

BIRTHPLACE (city or town) (State or country) Annapolis Md

10 NAME OF FATHER James R Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Co Md

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Co Md

Informant wife

(Address) same as above

Filed NOV 6 1930 H. H. JONES M.D. Registrar

A-6 AON

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1930, to Nov 8, 1930,

that I last saw h[illegible] alive on Nov 8th, 1930,

and that death occurred, on the date stated above, at 12.45 Pm.

The CAUSE OF DEATH* was as follows:

Toxemia of pregnancy Interstitial

Postpartum shock

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Strangulated hernia

(duration) yrs. mos. 1 day

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 8th 1930

Was there an autopsy? partial

What test confirmed diagnosis? operation

(Signed) Thomas H Slade, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery DATE OF BURIAL Nov 11 1930

20 UNDERTAKER Geo H Little ADDRESS 2700 Edmondson Ave

C.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62168

CERTIFICATE OF DEATH.

88 E 62168

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4107 LaSalle Ave., Raspeburg ST., 27th WARD) 27-42

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Marion Carter

(a) RESIDENCE NO. 4107 LaSalle Ave., Raspeburg, Md. ST., 27th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced ~~Husband of~~ (or) WIFE of William Henry Carter

DATE OF BIRTH (month, day, and year) Feb. 29, 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Washington, D.C.

10 NAME OF FATHER John C. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant (Address) Miss Nellie Carter 4107 LaSalle Ave., Raspeburg, Md.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29th, 1930, to Nov. 7, 1930,

that I last saw her alive on Nov. 7, 1930,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis 1 wk.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Williams, M. D.

11/8 1930 (Address) 5713 Belair Rd., Raspeburg, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pinelawn, Interment

DATE OF BURIAL Nov 10th 1930

20 UNDERTAKER George [illegible] & Sons

ADDRESS 1126 [illegible]

C. HAMPTON JONES, M. D.

Registrar

NOV 8 1930

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62169

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 62169

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No.) 2432 N. Calvert St. ST., 12-50 (WARD)

-FULL NAME Susan E. Sultzer.

(a) RESIDENCE NO. 2432 N. Calvert St, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) Dec. 17th. 1860

GE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	10	21	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Thomas D. Sultzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elenora Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mrs. William T. Sutton.

(Address) 2432 N. Calvert St.

Filed 11/9 1930 S. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1929, to Nov. 7, 1930,

that I last saw her alive on Nov. 7, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) Many yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical examination

(Signed) Forrest Smith M. D.

11/8, 1930 (Address) R 435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery. DATE OF BURIAL Nov. 10 1930

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt Royal Ave

1-30—M. & T.—250 Bks

E 62170 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62170

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH Baltimore City Hospitals

OF BALTIMORE: (No. 19-27 ST., WARD)

FULL NAME Essie Stanley

RESIDENCE NO. 222 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

If married, widowed, or divorced
(HUSBAND of
or) WIFE of -

DATE OF BIRTH (month, day, and year) Feb. 6, 1887

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	9		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Northumberland Va.

10 NAME OF FATHER James Pointdexter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D.C.

12 MAIDEN NAME OF MOTHER Lizzie Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Records of

(Address) Balto. City Hosp.

Filed 11-10-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-30

17 I HEREBY CERTIFY, That I attended deceased from 10-16-30, 19, to 11-6-30, 19,

that I last saw her alive on 11-6-30, 19,

and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

11-8, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetery

DATE OF BURIAL 11/10/1930

20 UNDERTAKER Mrs Lahas G. Bailey

ADDRESS 1421 Jefferson St

1-30—M. & T.—250 Blks

62171 HEALTH DEPARTMENT—CITY OF BALTIMORE 122-002 E 62171

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No. 3121 Dillon St ST., 1-1 WARD)

-FULL NAME Charles H. Hartley

) RESIDENCE NO. 3121 Dillon St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Widower

married, widowed, or divorced (HUSBAND of or) WIFE of Barbara C. Flaherty

TE OF BIRTH (month, day, and year) Nov 24, 1851

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	79	11	14	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Builder

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER William S. Hartley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Anna Bower

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Mr. Harry Hartley

(Address) 3121 Dillon St.

9-1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/1, 1930, to 11/6, 1930, that I last saw h[illegible] alive on 11/5, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

I Hepatic Cirrhosis, Myocarditis

II Nephritis, Pneumonia

(duration) yrs. mos 7 da.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos Farrell, M. D.

11/8, 1930 (Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additioonal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Nov. 10, 1930.

20 UNDERTAKER John A. Moran

ADDRESS 5000 E. Balto St.

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62172

CERTIFICATE OF DEATH.

129 E 62172

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
OF BALTIMORE: (No.) 1713 Hollins St. (Ward) 10-28
2. FULL NAME Mary A. Smith
3. (a) RESIDENCE NO. 1713 Hollins St. WARD
(Usual place of abode) (If non-resident give city or town and State)
(b) Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

6 If married, widowed, or divorced (a) HUSBAND of (or) WIFE of James Smith

7 DATE OF BIRTH (month, day, and year) Feb 14-1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.
10 NAME OF FATHER James Grainn
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Ann O'Shea
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mary A Smith
(Address) 1713 Hollins St

Filed 9- 1930 C. H. Pell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/30

17 I HEREBY CERTIFY, That I attended deceased from 11/6/ 1930, to 11/7/ 1930, that I last saw h-- alive on 11/7/ 1930, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:
(1) Cardiac Insufficiency
Chr. Interstitial myocarditis
arteriosclerosis
years — (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Coronary Thrombosis (duration) — yrs. — mos. 1 hours. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Examination

(Signed) J. T. Sheehan M. D.
11/8 1930 (Address) 804 Aliceal St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cem — DATE OF BURIAL 11/10/30
20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Baltimore

1-30—M. & T.—250 Bks.

62173 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62173

CERTIFICATE OF DEATH.

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

OF BALTIMORE; (NO. 14 Merrymount Rd ST. 27-53 WARD

2-FULL NAME Johanna Doetsch

3-(a) RESIDENCE NO. 14 Merrymount Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? 71 yrs. 5 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

married, widowed, or divorced HUSBAND of or WIFE of Louis J Doetsch

6 DATE OF BIRTH (month, day, and year) May 30 1859

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

10 NAME OF FATHER: Anton Pohl

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown Germany

12 MAIDEN NAME OF MOTHER: Emilie Tehning

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Germany

Informant: Ernest P Doetsch (son)

(Address): Baltimore Md

Filed 1930, 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7/30

17 I HEREBY CERTIFY, That I attended deceased from October 28, 1930, to November 7, 1930, that I last saw her alive on November 7, 1930, and that death occurred, on the date stated above, at 8:10 A m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis originating from Carcinoma breast

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 1926

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles I Hustmann, M. D.

Nov. 8, 1930 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL Nov 10 1930

20 UNDERTAKER: Stewart & Co — ADDRESS Baltimore

2-29-28—L. F. S.—500 Bks.

2174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

62174

REGISTERED NO. E 62174

-PLACE OF DEATH

Y OF BALTIMORE: (No. 1800 Riggs Ave. ST. 16-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-FULL NAME Ida Emily Ehrhardt

) RESIDENCE NO. 1800 Riggs Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
nale	White	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Frederick H. Ehrhardt

TE OF BIRTH (month, day, and year) Dec. 3, 1868

Years	Months	Days	If LESS than 1 day, hrs. or min.
61	11	4	

UPATION OF DECEASED

) Trade, profession or rticular kind of work Housewife

) General nature of industry, siness, or establishment in hich employed (or employer) 037

) Name of employer At Home

RTHPLACE (city or town) Baltimore County
tate or country) Maryland

0 NAME OF FATHER John Euler

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

2 MAIDEN NAME OF MOTHER Mary Stuntz

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Mr. Frederick H. Ehrhardt

(Address) 1800 Riggs Ave.

Filed [illegible] 19[illegible] [illegible] Registrar

-1930.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19 . 1925 . to Nov. 7 . 1930 , that I last saw h e alive on Nov. 7 . 1930 and that death occurred, on the date stated above, at 5.25 A. m.

The CAUSE OF DEATH* was as follows:

Arterioschlerosis & Hypertension.

about (duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

11/8 . 1930 (Address) 1101 N. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem. Catonsville

20 UNDERTAKER Joseph B. Cook

DATE OF BURIAL Nov. 10 1930

ADDRESS 1005 West Baltimore St

10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62175

E 62175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

y of Baltimore: (No. 1500 W. Lexington St., 19-27 Ward)

2-FULL NAME Annie M Reid

(a) RESIDENCE NO. 1500 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas

DATE OF BIRTH (month, day, and year) Feb. 11, 1850

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	80	8	26	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER Thos Rambo

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Rachel Schantz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Ida M. Hoffman
(Address) 1500 W. Lexington

15 [illegible] Registrar

10 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

a Cerebral Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas O'Brooke M. D.
Nov 8. 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL 11/10/30

20 UNDERTAKER J. Vernon Kelhart — ADDRESS 1833 Hollins St.

1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62176

CERTIFICATE OF DEATH. X 122.002 E 62176

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 79 WARD)

FULL NAME Charles F. Crawford

(a) RESIDENCE NO. Fall Branch, Tenn. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	Married

married, widowed, or divorced
HUSBAND of
or ~~WIFE of~~ MINNIE

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 87

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Tenn

10 NAME OF FATHER James Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Sarah Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

Informant Friends

(Address) JOHNS HOPKINS HOSP. BALTO. MD.

Filed NOV 10 1930, 19 JCK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/30

17 I HEREBY CERTIFY, That I attended deceased from October 20, 1930, to November 8, 1930

that I last saw h[illegible] alive on November 8, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis ?

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 11-20

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Rawley M. Leuch Jr M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greeneville Tenn

DATE OF BURIAL 11/11/30

20 UNDERTAKER Joseph Abrams

ADDRESS 221 Bway

Spec. 17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62177

E 62177

REGISTERED NO. 27-41

1-PLACE OF DEATH

City of BALTIMORE: (No. 5136 Harford Ave St.) Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Margaret Hummer

(a) RESIDENCE NO. 5136 Harford Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth?— yrs.— mos.— ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Jesse Owen Hummer

DATE OF BIRTH (month, day, and year): Nov. 30 - 1860

7 AGE — Years: 69 Months: 11 Days: 10

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Buckhorn Columbia Co Pa

PARENTS

10 NAME OF FATHER: William Hartman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Barbara Reedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): La Porte, Penna

14 Informant (Address): Mr. Joseph H Hummer 137 E. Allen St State College

15 Filed NOV 10 1930 19 Registrar

STATE HOSPITAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Nov. 9-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Nov 9, 1930, that I last saw h. alive on Nov. 8, 1930, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon, M. D.

11/9, 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Danville Pa.

Date of Burial: Nov 1930

20 UNDERTAKER: W. F. Williamson

ADDRESS: Oakdale

62178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62178

Registered No. C.....

1-PLACE OF DEATH: Union Memorial St. 407-412 Ward

City of BALTIMORE (No.

2-FULL NAME James M. Costin Sr

Residence in Baltimore, No. 3800 Pinewood Ave ...St.; yrs... mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Married

6-DATE OF BIRTH: Sept (Month) 10, (Day) 1850 (Year)

7-AGE: 80 yrs. 1 mos. 27 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION (a) Trade, profession, or particular kind of work: Capt S.B. Sexton Ins. (b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE (State or Country): N.C.

10-NAME OF FATHER: Saml. Costin

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Caroline Bowie

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Medora C. Costin

(Address) 3800 Pinewood Ave

15-

Filed ... 1930 ... Registrar

TO 1939

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 7 (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the date stated above.

The CAUSE OF DEATH* was as follows:

Paralysis Duration

Of Heart

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...ds.

(Signed) ... M. D. (Coroner.)

11/9 1930 (Address) 1672 Rolandvue

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery DATE OF BURIAL: Nov. 10. 1930

20-UNDERTAKER: Wm. J. Rickert & Sons ADDRESS North & C

62179

HEALTH DEPARTMENT—CITY OF BALTIMORE

43

E 62179

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH Mercy Hospital. (No. 1668 ST., WARD)

OF BALTIMORE: (NO.)

FULL NAME Louis Chaillon

(a) RESIDENCE NO. 2709 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Chaillon

6 DATE OF BIRTH (month, day, and year) Jan. 1 1852

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Sergeant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 061

(c) Name of employer Balto Police Dept Baltimore

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Stanislaus Chaillon

11 BIRTHPLACE OF FATHER (city or town) Paris (State or country) France.

12 MAIDEN NAME OF MOTHER Barbara Emerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France.

Informant Helen Chaillon

(Address) 2709 Mosher St.

Filed NOV 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9/30.

17 I HEREBY CERTIFY, That I attended deceased from 10/28, 1930, to 11/9, 1930, that I last saw him alive on 11/8, 1930, and that death occurred, on the date stated above, at 4.32 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mouth.

(duration) yrs. 1 mos 7 ds. ?

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10/30/30.

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) J. T. McAndrew, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Nov 11 1930

20 UNDERTAKER W. J. Tickner & Sons

ADDRESS North Ave

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE. E 62180

62180

CERTIFICATE OF DEATH.

45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. Mercy Hospital ST. 8-45 WARD)

FULL NAME Ella McAuliffe

RESIDENCE NO. 1679 Clifton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	Single

married, widowed, or divorced
HUSBAND) of
or) WIFE of

ATE OF BIRTH (month, day, and year) ~~May~~ Oct. 17 1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Cornelius McAuliffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Hospital Records

(Address)

Filed 10 1930 H. M. JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-30

17 I HEREBY CERTIFY, That I attended deceased from 10-30, 1930, to 11-6, 1930,

that I last saw h[illegible] alive on 11-6, 1930,

and that death occurred, on the date stated above, at 5 40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma sigmoid colon

(duration) (?) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/31/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) J Leyko, M. D.

11/6, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 11/10/1930

20 UNDERTAKER H. J. Fanning & Son - 1938 E. Lafayette Ave

ADDRESS

—9-30—A. & Co.—250 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62181

CERTIFICATE OF DEATH.

E 62181

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 8 S Monroe St. (WARD) 14-28

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Bridget McInerney

(a) RESIDENCE NO. 8 S Monroe St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael McInerney

DATE OF BIRTH (month, day, and year): May 1855

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	5		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Ireland

10 NAME OF FATHER: George Shanks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Hanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Anna McInerney

(Address): 8 S Monroe St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6, 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 1930, to Nov 6, 1930

that I last saw her alive on Nov 6, 1930

and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Intestinal Carcinoma

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

11/8, 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 11/10/30

20 UNDERTAKER: Engelke Funeral Home

ADDRESS: Fulton & Fayette

C. HAMPSON JONES, M. D.

& T —100 B—50L

2182.

Cruz

E. 62182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

187-006

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

OF BALTIMORE: (No. 2d Glen Hosp ST. 7-4 WARD)

FULL NAME Antonia Fernandez (Cruz)

RESIDENCE NO 2 25 Shakespeare ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Male White

5 Single, Married, Widowed, or Divorced (write the word): Married

arried, widowed, or divorced HUSBAND of or) WIFE of: Consuela —

E OF BIRTH (month, day, and year): Feb 17-1881

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	8	18	

CUPATION OF DECEASED
) Trade, profession or articular kind of work: Laborer
) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

THPLACE (city or town) State or country): Spain

NAME OF FATHER: Antonia Cruz

BIRTHPLACE OF FATHER (city or town) (State or country): Spain

MAIDEN NAME OF MOTHER: Consuela Cruz

BIRTHPLACE OF MOTHER (city or town) (State or country): Spain

formant: Wife & Next Record

(Address): 2d Glen Hosp

Filed ..... 19 ..... By ..... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured femur Acute Abdominal Viscera with Rupture

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cause or Shock from

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ..... Date of .....

Did an operation precede death? No

Was there an autopsy? .....

What test confirmed diagnosis? Regular

(Signed) ..... M. D.

(Address) ..... Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Louis Cemetery

DATE OF BURIAL 11/10/30

20 UNDERTAKER Sauer Sons

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

180-003

E 62183

CERTIFICATE OF DEATH.

62183

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) 4301 Keswick Road (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Streett Edgett

Residence in Baltimore: No. 4301 Keswick Rd. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

DATE OF BIRTH: July 13th, 1930 (Month) (Day) (Year)

AGE: 0 yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work: ——
(b) General nature of industry, business, or establishment in which employed (or employer): ——

BIRTHPLACE (State or Country): Balto Md.

10-NAME OF FATHER: Eugene A. Edgett

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Cecilia Streett

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Paola Billotti

(Address) 1625 E 25th St City

Filed OCT 10 1930 HAMPSON JONES, M. D. 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8, 1930 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the date stated above.

The CAUSE OF DEATH* was as follows:

Suffocation

Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F. Mowbray M. D. (Coroner.)

10/9/30 (Address) 2622 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Rock Spring Cem Forest Hill Md

DATE OF BURIAL: Oct 10 1930

20-UNDERTAKER: Henry A. Jenkins Sons

ADDRESS: McCulloh & Orchard Sts.

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62184 E 62184

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 17-24 WARD)

-FULL NAME Charles Harvey

a) RESIDENCE NO. 55 8 Dolphin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Married

married, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year) 1872

GE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Abner Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/30

17 I HEREBY CERTIFY, That I attended deceased from October 21, 1930 to November 8 1930,

that I last saw him alive on November 8, 1930,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

-Post-operative
bronchio-pneumonia
Carcinoma of stomach.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 10-30-30

Was there an autopsy? no

What test confirmed diagnosis?* .....

(Signed) I. R. Trimble M. D.

Nov 9, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Balto DATE OF BURIAL 11/10/30

20 UNDERTAKER Arnold Hemsley ADDRESS 1 E Baltimore St

—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62185

REGISTERED NO. E 62185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 62185

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St., Ward) 20-69 170

2-FULL NAME Robert E Jacobs

(a) RESIDENCE NO. 328 Smallwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Carie Jacob

DATE OF BIRTH (month, day, and year) Dec 16 1898

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	10	21	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Taxicab Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Yellow Cab
(c) Name of employer

BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER John F Jacob

11 BIRTHPLACE OF FATHER (city or town) Balto, Md
(State or country)

12 MAIDEN NAME OF MOTHER Lillie St. Meyers

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md
(State or country)

14 Informant John L Jacob
(Address) 2443 Eden St

15 Filed NOV 10 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide, Pistol shot
in head

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Brooke, M. D.

Nov 7, 1930 (Address) 8 Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DATE OF BURIAL Nov 10 1930

20 UNDERTAKER F. B. Seppert ADDRESS 335 Edmondson Ave

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62186

CERTIFICATE OF DEATH

74-001

E 62186

REGISTERED NO.

—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (No. 5612 Park Heights ave ST., 27-55 WARD)

—FULL NAME Wolf Magid

) RESIDENCE NO. 5612 Park Heights ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

h of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of: Esther

TE OF BIRTH (month, day, and year): 1853

E	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	—	—	

CUPATION OF DECEASED

) Trade, profession or articular kind of work: Cantor

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) (State or country): Russia

0 NAME OF FATHER: Solomon Magid

1 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

2 MAIDEN NAME OF MOTHER: Reba —

3 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: Mrs Esther Magid

(Address) 5612 Park Heights ave

Filed 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 10/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930, to Nov 10, 1930, that I last saw h[illegible] alive on Nov 9, 1930 and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? history examination

(Signed) Jacob Cohen, M. D.

Nov 0, 1930 (Address) 223 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: Nov. 10 1930

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Balto St

M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62187

90 E 62187

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

TY OF BALTIMORE: (No. 1624 E. Madison ST., 1-13 WARD)

2-FULL NAME Rachel Johnson

(a) RESIDENCE NO 1624 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	black	widow

If married, widowed, or divorced HUSBAND of (or) WIFE of John Johnson

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	74			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) of
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Co. Md

10 NAME OF FATHER Thos. B. Todd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Co., Md.

12 MAIDEN NAME OF MOTHER Charity Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co., Md.

14 Informant Clara Dodson (Granddaughter)

(Address) 1624 E. Madison

Filed Nov 10 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], Coroner, M. D.

Nov 10 1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn — DATE OF BURIAL 11-11 1930

20 UNDERTAKER Jas. M. Skinner — ADDRESS 1625 E. Madison St

1-30—M. & T.—250 Blks

62188 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 62188

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No. 2325 Callow Ave., ST. 13-59 WARD)

-FULL NAME Gitty V. Lavenstein

(a) RESIDENCE NO. 2325 Callow Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	White	Widowed

married, widowed, or divorced HUSBAND of (or) WIFE of Louis Lavenstein

TE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Jacob Rosenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address)

Filed NOV 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1930, to Nov 10, 1930, that I last saw her alive on Nov 9, 1930, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Obstruction of intestines (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I. Frederick Lehr, M. D.

11-10 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levindale Cemetery

DATE OF BURIAL 11-12-1930

ADDRESS

20 UNDERTAKER Ace Lewis

C.—1-10-21—MAT—1500 Blks.

62189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 62189

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital WARD

CITY OF BALTIMORE, (No.) Wilkins & Edmondson ST.

2-FULL NAME Frances Ensley

(a) RESIDENCE NO. 2573 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 15 th 1920

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	11	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (none)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanley Ensley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Stanley Ensley (Address) 2573 Frederick Ave

15 Filed NOV 10 1930 16 HARRY C. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1930, to Nov. 7, 1930, that I last saw h[illegible]alive on Nov. 7, 1930, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Meningitis - Tuberculous (duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Type not det.) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence -

Did an operation precede death? no Date of

Was there an autopsy? Yes -

What test confirmed diagnosis? T.B. Bacillus in Sp.

(Signed) Fleud Koontz M. D.

19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

20 UNDERTAKER A. Jones

DATE OF BURIAL Nov 11 1930

ADDRESS 111 S Gilmor

& T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 62190

2190

CERTIFICATE OF DEATH

REGISTERED NO. .....

PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

OF BALTIMORE: (No.) Bolto Eye Ear Thr 58 St. ... WARD) Goldsmith.

FULL NAME Emanuel H. Goldsmith

RESIDENCE NO. 3509 Reisterstown Rd. St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred ... yrs 2 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE — 5 Single, Married, Widowed, or Divorced (write the word)

Wh | Wid

arried, widowed, or divorced (HUSBAND of or) WIFE of

TE OF BIRTH (month, day, and year) Aug 23-1862

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	2	10	

CUPATION OF DECEASED
) Trade, profession or rticular kind of work Retired.
) General nature of industry, siness, or establishment in hich employed (or employer)
) Name of employer

THPLACE (city or town) Baltimore Md
tate or country)

NAME OF FATHER Hermann Goldsmith

BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

MAIDEN NAME OF MOTHER Henrietta Moses

BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

formant Jacob Manning
(Address) 3504 Reisterstown Rd

Filed ... 192 ... Registrar

0 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home Date of ... Nov 8.

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) ... M. D. Coroner

(Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Jewish Cem. | DATE OF BURIAL Nov 10 1930

20 UNDERTAKER J. Abrams & Co. | ADDRESS ... Reisterstown Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓

REGISTERED NO. B 62191

E 62191

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1841 Duncan St. 8-16 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Whittle

(a) RESIDENCE NO. 1841 Duncan St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6 If married, widowed, or divorced, (or) WIFE of Elizabeth Whittle

7 DATE OF BIRTH (month, day, and year) Oct. 4 1862

AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
68				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. County

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

PARENTS

14 Informant Mrs. Elizabeth Whittle

(Address) 1841 Duncan St.

15 Filed ..... C. HARRISON JONES, M. D. Registrar

DEC 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8/30 19

17 I HEREBY CERTIFY, That I attended deceased from July, 1930, to Nov 7th, 1930, that I last saw h[illegible] alive on Nov 7th, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

Emphysema of Chest

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Tankersley, M. D.

19 (Address) 1192 Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Nov. 10, 1930

20 UNDERTAKER Culey & Co. Inc. ADDRESS 821 Hollins Ave

& T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 62192

62192

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

OF BALTIMORE: (No. St. Joseph Hospital St. 6-10 WARD)

FULL NAME William H. Einhaus

) RESIDENCE NO 115 N. Belnord ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
e	white	married

arried, widowed, or divorced (HUSBAND of (or) WIFE of Catherine Einhaus

TE OF BIRTH (month, day, and year) Jan 7/1898

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
32	10	0	

CUPATION OF DECEASED
) Trade, profession or articular kind of work Motorman
) General nature of industry, siness, or establishment in hich employed (or employer)
) Name of employer United Railways Balto. Co., Md.

THPLACE (city or town) (State or country)

) NAME OF FATHER John H. Einhaus

BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co., Md.

2 MAIDEN NAME OF MOTHER Eva M. Maddox

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co., Md.

Informant Catherine Einhaus (wife)

(Address) 115 N. Belnord Ave

Filed ..... Registrar .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) ..... Coroner, M. D.

Nov 10/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn. DATE OF BURIAL Nov 11 30

20 UNDERTAKER Gilles Leiber ADDRESS 403 S. Wolfe St.

Filed NOV 15 1930 (Mrs.) Joseph Jones, M. D. Registrar

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62193

CERTIFICATE OF DEATH.

90 E 62193

REGISTERED NO.

-PLACE OF DEATH

OF BALTIMORE: (No. 111 N. Port ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-FULL NAME John Trohnaffel

(a) RESIDENCE NO. 111 N. Port ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

gth of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Trohnaffel

TE OF BIRTH (month, day, and year) July 1856

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	4		

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Show Case Factory

(c) Name of employer

IRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Caroline Trohnaffel

(Address) 111 N. Port St.

Filed NOV 10 1930 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Nov 6, 1930, that I last saw h[illegible] alive on Nov 6, 1930, and that death occurred, on the date stated above, at 10 40 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was autopsy? —

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) 173 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Nov. 11 1930

20 UNDERTAKER Zell & Zeiler Inc

ADDRESS 403 S Wolfe St

1-30—M. & T.—250 Bks

62194 HEALTH DEPARTMENT—CITY OF BALTIMORE 3 E 62194

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No. 3409 Foster ave ST., 26-1 WARD)

-FULL NAME Nicholas H Nuedling

) RESIDENCE NO. 3409 Foster ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) July 23rd 1910

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	3	15	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typewriter Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John O. Nuedling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Eliz. Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

Informant Elizabeth Nuedling (Mother)
(Address) 3409 Foster ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 7 1930, to Nov 7 1930,

that I last saw him alive on Nov 7 1930,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Bilateral) advanced

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arnold J. Kuehnau, M. D.

11-8, 1930 (Address) 3507 Fait ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL Nov 11th 1930

20 UNDERTAKER Lilly & Geiler Inc.

ADDRESS 400 S Wolfe st

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 62195

62195

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. West Balto Gen Hosp ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Estelle Chappell

RESIDENCE NO. 1344 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Stevens Chappell

DATE OF BIRTH (month, day, and year): Unknown 1899

Years	Months	Days	If LESS than 1 day, hrs. or min.
31			

OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work: Housewife

b) General nature of industry, business, or establishment in which employed (or employer): 037

c) Name of employer

BIRTHPLACE (city or town) (State or country): Md.

NAME OF FATHER: Unknown

BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

MAIDEN NAME OF MOTHER: Unknown

BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant: Stevens Chappell

(Address) 1344 Mosher Street

Filed ____, 19____ Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/7/30

17 I HEREBY CERTIFY, That I attended deceased f[rom] 11/1, 1930, to 11/7, 19[30]

that I last saw h[er] alive on 11/7

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Bilateral Tubo Ovarian Pelvic cases
Mechanical Obstruction (Intestinal)

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/5/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. Eastman, M. D.

(Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary

DATE OF BURIAL: Nov. 10, 1930

20 UNDERTAKER: Mrs R. A. Elliott

ADDRESS: 116 Ashland Ave

1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62196 101-08 E 62196

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

Y OF BALTIMORE: (No. 1605 Bauer ST., 713 WARD)

-FULL NAME Annie Marshall

a) RESIDENCE NO. 1605 Bauer ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
X	Col.	Married

married, widowed, or divorced
HUSBAND) of
or) WIFE) of Richard Marshall

ATE OF BIRTH (month, day, and year) Oct. 8, 1909

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
21		1		

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) N.C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Richard Marshall
(Address) 1605 Bauer

Filed 11-10, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8-30

17 I HEREBY CERTIFY, That I attended deceased from 10/30, 1930, to 11/8, 1930, that I last saw her alive on 11/8, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 8 yrs. 9 mos 8 ds.

CONTRIBUTORY (Secondary) Bronchitis & Tonsilitis

(duration) ....yrs. ....mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Signs & Symptoms

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/8, 1930 (Address) 724 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winona Md. DATE OF BURIAL Nov 10, 1930

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Eastlandave

2-29-28—L. F. S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62197 — 101-001 — E 62197

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) 511 Orchard ST. (WARD) 17-24

FULL NAME Cetio Smith

RESIDENCE NO. 511 Orchard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	col	married

married, widowed, or divorced HUSBAND of ~~WIFE of~~ Rebecca Smith

TE OF BIRTH (month, day, and year) September 1889

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
41			

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Laborer. 040

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Md.
tate or country)

NAME OF FATHER Unknown

1 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or country)

Informant Rebecca Smith,

(Address) 511 Orchard Street

FILED JAN 10 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1930, to Nov 7, 1930,

that I last saw him alive on Nov 6, 1930

and that death occurred, on the date stated above, at 2.55 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Weigand, M. D.

1/7, 1930 (Address) 625 Schroeder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL Nov. 10, 1930

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1725 Ashland Ave

2-29-28—L. F. S.—500 Blks.

198
2198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-002

E 62198

REGISTERED NO.

—PLACE OF DEATH

Y OF BALTIMORE: (No. 1235 S. Decker Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Clara S. Korzeniewsky

) RESIDENCE NO. 1235 S. Decker Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
nale	White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) May 2, 1930

Years	Months	Days	If LESS than 1 day.. hrs. or .. min.
	6	6	

UPATION OF DECEASED

) Trade, profession or rticular kind of work dd

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Balto Md.
tate or country)

0 NAME OF FATHER Walter Korzeniewsky

1 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

2 MAIDEN NAME OF MOTHER Katie Korzeniewski

3 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

Informant Walter Korzeniewski

(Address) 1235 S. Decker Ave

Filed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from November 6, 1930, to November 8, 1930.

that I last saw h alive on November 7, 1930

and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry E. Wilson M. D.

, 19 (Address) 13 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

N. Stanislaus Cem

DATE OF BURIAL

Nov. 10 1930

20 UNDERTAKER

Stefanowski Funeral Home Inc.

ADDRESS

1000 N. Kenwood Ave

1-30—M. & T.—250 Bks

E 62199

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62199

CERTIFICATE OF DEATH.

REGISTERED NO. 90

-PLACE OF DEATH Baltimore City Hospitals ST. 5-8 WARD)

Y OF BALTIMORE: (No. ..... ST., ... WARD .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-FULL NAME Joseph Farrell

a) RESIDENCE NO. Levering House ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
le	White	Single

married, widowed, or divorced
HUSBAND of
or) WIFE of -

TE OF BIRTH (month, day, and year) Dec. 24, 1854

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	76	10	13	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto.
(State or country) Md.

10 NAME OF FATHER Thomas Farrell

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Annie Stanton

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

Informant Records of
(Address) Balto. City Hospitals

Filed 1930 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-7-30

17 I HEREBY CERTIFY, That I attended deceased from 7-27-25, 19..., to 11-7-30, 19..., that I last saw him alive on 11-7-30, 19..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Heart disease, arteriosclerotic
(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

11.8, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 11/10/1930

20 UNDERTAKER John J. Fahey Sons — ADDRESS 1318 Eight St

Rec.—1-10-21—M&T—1500 Blks.

E 62200 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62200

CERTIFICATE OF DEATH.

REGISTERED NO. 1291

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 411 Mt. Holly ST., 20-10 WARD)

2-FULL NAME Mary Cidt Mary Anna Cidt

(a) RESIDENCE NO. 411 Mt. Holly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced (a) HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 2 1868 ~~1867~~

AGE 62 Years 1 Months 15 Days

If LESS than 1 day, hrs or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Louis Cudt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Nann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry Cudt

(Address) 411 Mt Holly St

15 101930 C. HAMPSON JONES, M. D. Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1929, to Nov. 8, 1930,

that I last saw h[illegible] alive on Nov. 6 th, 1930,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

immediate (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) F. Lebrote Ewald, M. D.

11/10, 1930 (Address) 2945 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Ce

DATE OF BURIAL 11-11 1930

20 UNDERTAKER Jos A Farley

ADDRESS 1700 N Fayette

1-30—M. & T.—250 Blks.

62201 HEALTH DEPARTMENT—CITY OF BALTIMORE 10 E 62201

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

(a) OF BALTIMORE: (No. Lyderhorn Hospital ST. 15-61 WARD)

2-FULL NAME Walter Fowler

(b) RESIDENCE NO. 2173 Forest Park Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

(c) Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7, 1927

7 AGE: Years 3 | Months 9 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

10 NAME OF FATHER William Fowler

11 BIRTHPLACE OF FATHER (city or town) Annapolis (State or country) Maryland

12 MAIDEN NAME OF MOTHER Estelle Peddicord

13 BIRTHPLACE OF MOTHER (city or town) Eastport (State or country) Maryland

Informant Mrs. Esther Fowler

(Address) 2173 Forest Park Av

Filed NOV 10 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1930, to Nov 9, 1930, that I last saw him alive on Nov 9, 1930, and that death occurred, on the date stated above, at 3 20 p.m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) 0 yrs. 0 mos 7 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? 2173 Forest Park Av.

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Cultures from throat

(Signed) J. Peter Merenghi M. D.

, 19 (Address) Lyderhorn Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Nov 10 1930

20 UNDERTAKER John F Denny — ADDRESS [illegible]

1-30—M. & T.—250 Bks.

2202 HEALTH DEPARTMENT—CITY OF BALTIMORE 114 v

CERTIFICATE OF DEATH.

REGISTERED NO. E 62202

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
(a) CITY OF BALTIMORE: (No.) 336 Penn ave St. 17-24 WARD)

2. FULL NAME Judy Lenard

(a) RESIDENCE NO. 1336 Penn ave St., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	R.	Widowed

married, widowed, or divorced HUSBAND of (or) WIFE of Lenard Bernard

6 DATE OF BIRTH (month, day, and year) 1869-

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	-	-	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private home

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) N. Carolina

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

Informant John H. Cooper

(Address) 133 E. Preston

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3 1930, to Nov. 8th 1930,

that I last saw h alive on Nov. 6th 1930,

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age Toxaemia
Acute Attack of Chronic Nephritis
Simple Diarrhea

(duration) yrs., mos. 14 ds.

CONTRIBUTORY (Secondary) Simple Diarrhea (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? v

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philip A. Lee Ellis, M. D.

(Address) 32 + Monument ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL Nov. 11 1930

20 UNDERTAKER Eugene Waters — ADDRESS 512 N Carrollton ave

NOV 10 1930 MARY L. JONES, M. D.

2-29-28—L. F. S.—500 Bks.

62203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62203

REGISTERED NO. 28-64

—PLACE OF DEATH

Y OF BALTIMORE: (No. 3411 Milford St. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Elizabeth Corcoran

) RESIDENCE NO. 3411 Milford St. WARD

(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred 96 yrs. 3 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (Write the word)
white	Widow

married, widowed, or divorced
HUSBAND of
(or) WIFE of Gilbert Corcoran

TE OF BIRTH (month, day, and year) Aug 19 1834

Years	Months	Days	If LESS than 1 day, hrs. or min.
96	3	21	

EPATION OF DECEASED

) Trade, profession or rticular kind of work None

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Baltimore

) NAME OF FATHER Thomas D. Smith

) BIRTHPLACE OF FATHER (city or town) Baltimore

2 MAIDEN NAME OF MOTHER Sarah Ranagey

3 BIRTHPLACE OF MOTHER (city or town) Baltimore

Informant Charles L. Corcoran

(Address) 3411 Milford St.

Filed OCT 10 1930 H. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Nov 9, 1930,

that I last saw h alive on Nov. 9, 1930

nd that death occurred, on the date stated above, at 1.0 m.

The CAUSE OF DEATH* was as follows: Valvular Heart Disease + Hardening of Arteries

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no. Clinical

What test confirmed diagnosis?

(Signed) A. E. Bloom M.D.

11/10 1930 (Address) 1901 Harrison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 12 1930
20 UNDERTAKER	ADDRESS
J. J. Sanders & Son	2173 Pa. Ave

2-29-28—L. F. S.—500 Bks.

62204 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 E 62204

CERTIFICATE OF DEATH

REGISTERED NO.

PLACE OF DEATH Franklin Square Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (No. 17-25 ST. WARD)

FULL NAME Mary Trautman

) RESIDENCE NO. Green Heights ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

married, widowed, or divorced
HUSBAND of (or) WIFE of Harry C Kaufman

TE OF BIRTH (month, day, and year) 6/10/1883

Years	Months	Days	If LESS than 1 day, hrs. or min.
47	4	28	

CUPATION OF DECEASED

) Trade, profession or particular kind of work: Housewife

) General nature of industry, business, or establishment in which employed (or employer):

) Name of employer:

RTHPLACE (city or town) Baltimore Md
State or country)

0 NAME OF FATHER John Deeker

1 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

2 MAIDEN NAME OF MOTHER Ellen Henckle

3 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

Informant Mrs. John Blair

(Address) 4236 Redwood Ave

Filed NOV 1 1930 HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to Nov 8, 1930, that I last saw her alive on 11-8, 1930, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma
Tertiary Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-16-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. W. Peake M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westview Cemetery

DATE OF BURIAL: 11/11/1930

20 UNDERTAKER: H. Brammer Sons

ADDRESS 1136 Poplar Grove

10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62205 — 170 — E 62205

REGISTERED NO. .....

1-PLACE OF DEATH
(a) City of Baltimore: (No.) Pronounced dead at St., Ward (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W Anthony

(a) RESIDENCE NO. 3 - S. Payson St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, ~~Married, Widowed or Divorced. (Write the word)~~
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 18th 1893

AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	37		20	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER George W. Anthony

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Burke

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. Annie Hutchinson
(Address) 3 S. Payson St.

15 Filed ..., 19... C. HAMPSON JONES, Registrar.

CORONER'S CERTIFICATE OR DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide - Pistol shot in head at home

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Brooks M. D.
Nov 8 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westview Cemetery — DATE OF BURIAL Nov 11th 1930

20 UNDERTAKER: Vernon Feehner — ADDRESS 1632 Hollins

NOV 10

-1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2206

E 622065

88 V-

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1032 N. Spring ST. 5-9 WARD)

2-FULL NAME Martha A. Mckay

(a) RESIDENCE NO. 1032 N. Spring ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mch. 6 - 1851

AGE: Years 79 | Months 8 | Days 2 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant: Jones & Mary (Address) 1032 N. Spring

Filed NOV 10 19 20 BALTIMORE, MD. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/25 1930 to 11/7 1930

that I last saw her alive on 11/7 1930

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) H. H. Slaker, M. D.

19 1930 (Address) 924 Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem.

DATE OF BURIAL: Nov. 11 1930

20 UNDERTAKER: Mrs J. G. Locke

ADDRESS: 1302 Jefferson

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62207 38 E 62207

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH (a) Baltimore City Hospt.
(b) OF BALTIMORE: (NO.) Baltimore, Md. (ST.) 18-6 (WARD)

FULL NAME Nellie Janey

(a) RESIDENCE NO. 804 Vine St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
(b) Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

(If married, widowed, or divorced) HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1894 1906

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
36			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer .....

8 BIRTHPLACE (city or town) (State or country) Maryland

9 NAME OF FATHER John C. Janey

10 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

11 MAIDEN NAME OF MOTHER Lena Turner

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Records
(Address) Balto City Hospt.

Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-30

17 I HEREBY CERTIFY, That I attended deceased from 8-7-, 1928, to 11-6, 1930, that I last saw h... alive on 11-6, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cystic infection
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical evidence & Path.

(Signed) Harry Friedman M. D.

11/7, 1930 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 11-10, 1930

20 UNDERTAKER David Carlin

ADDRESS Dundalk

31 AUG

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62208

CERTIFICATE OF DEATH

129 E 62208

REGISTERED NO. 15521

—PLACE OF DEATH

Y OF BALTIMORE: (No.) 1717 Pleasant St (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Cecelia Woodland

h) RESIDENCE NO. 1717 Pleasant St WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	Colored	Widow

married, widowed or divorced
HUSBAND of (or) WIFE of Joseph C Woodland

TE OF BIRTH (month, day, and year) June 1878

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5		

CUPATION OF DECEASED

) Trade, profession or particular kind of work Domestic

) General nature of industry, business, or establishment in which employed (or employer) 670

) Name of employer

RTHPLACE (city or town) St Mary Co Md
State or country)

0 NAME OF FATHER Thomas Johnson

1 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

2 MAIDEN NAME OF MOTHER Cecelia Young

3 BIRTHPLACE OF MOTHER (city or town) St Mary Co Md
(State or country)

Informant Raymond E Scarborough

(Address) 1717 Pleasant St

C. HAMPSON JONES, M. D. Registrar

1930 By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9/30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1930, to Nov 9th 30

that I last saw her alive on Nov 9th 1930

and that death occurred, on the date stated above, at 3.05 m.

The CAUSE OF DEATH* was as follows:

Chronic Laryngitis
Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Leo H Langenbacher M.D.

11-10, 1930 (Address) 2218 N Charles Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL Nov 12, 1930

20 UNDERTAKER Laurence E Dorsey ADDRESS 1200 N Eutaw

1-30—M. & T.—250 Bks.

62209 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62209

CERTIFICATE OF DEATH. 124

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH Provident Hosp.

OF BALTIMORE: (No. 514 Division ST. 1124 WARD)

-FULL NAME Joseph Roscoe Boyce

a) RESIDENCE NO. 200 N. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
le	Colored	Single

married, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43 yrs			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balt. Co. Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mary Boyce

(Address) 720 Falls Road

Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9/30

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1930, to Nov. 9, 1930, that I last saw him alive on Nov. 9, 1930, and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac dilitation

(duration) Unknown

CONTRIBUTORY (Secondary) Myocardial disease (CHT) & Nephrosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. George McDonald M. D.

11/9, 1930 (Address) 900 N. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL Nov 12 1930

20 UNDERTAKER W. S. Marshall ADDRESS 2539 Falls Road

1-30—M. & T.—250 Bks

62210 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62210

CERTIFICATE OF DEATH. 129 V

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

(a) OF BALTIMORE: (No. 5006 Clenmore Ave. 27-56 WARD)

2. FULL NAME Mrs Carrie Walters

(a) RESIDENCE NO. 5006 Clenmore Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

(Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

(If married, widowed, or divorced) HUSBAND of (or) WIFE of George Walters

6 DATE OF BIRTH (month, day, and year) March 17 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Attending Sick

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fort Washington Md

10 NAME OF FATHER Jos. Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co.

Informant Wm Rutter

(Address) 5006 Clenmore Ave

Filed 0 1930, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1930, to Nov. 8, 1930, that I last saw her alive on Nov. 8, 1930, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer Buccata - Primary

Regurgitation - Cardiac

(duration) 2 yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) C. H. Burton, M. D.

11. 9. 1930 (Address) Fort Washington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Nov 12 1930

20 UNDERTAKER H. S. Marshall ADDRESS 3139 Gall Rd

1-30—M. & T.—250 Bks.

2211 HEALTH DEPARTMENT—CITY OF BALTIMORE E 6221

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

a) OF BALTIMORE: (No. 141 Colvin ST. 5-8 WARD)

2. FULL NAME Harrison Black

b) RESIDENCE NO. 141 Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

6 If married, widowed, or divorced (a) HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1890

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. Carroll Co

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant John Watkins

(Address) 141 Colvin

14 C. HAMPSON JONES, M. D. Registrar

0-1930 1868

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 '30

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1930, to Nov 7, 1930, that I last saw h. alive on Nov 7, 1930, and that death occurred, on the date stated above, at 11.50 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

(Address) 351 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem.

DATE OF BURIAL 11-12 1930

20 UNDERTAKER Byron & Wright

ADDRESS 1218 N. Caroline St.

-1-30—M. & T.—250 Bks.

E 62212 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62212

153

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH Union Memorial Hospital
OF BALTIMORE: (No. 33rd & Calvert St. St. 43-[illegible] WARD
-FULL NAME Geraldine Shifflett
) RESIDENCE NO. 1510 W 36th St. ST., ... WARD Baltimore
(Usual place of abode) (If non-resident give city or town and State)
th of residence in city or town where death occurred 4 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

married, widowed, or divorced
HUSBAND of
or) WIFE of —

TE OF BIRTH (month, day, and year) Jan 31 1926

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	2		

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work —

b) General nature of industry, business, or establishment in which employed (or employer) —

c) Name of employer —

RTHPLACE (city or town) (State or country) Maryland.

10 NAME OF FATHER Albert Shifflett.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hesslie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records
(Address)
C. HAMPSON JONES, M. D.
0 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1930, to Nov 8, 1930, that I last saw h[illegible] alive on Nov 8, 1930, and that death occurred, on the date stated above, at 10 35 P m.

The CAUSE OF DEATH* was as follows:
General Septicemia.

(duration) 0 yrs. 0 mos 1 ds.

CONTRIBUTORY (Secondary) abscesses of leg (duration) 0 yrs. 0 mos. 8 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of 11-8-30
Was there an autopsy? no
What test confirmed diagnosis? laboratory

(Signed) Jesse S. Fox M. D.
, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md
DATE OF BURIAL Nov 11, 1930
20 UNDERTAKER Thenowetholm
ADDRESS 3610 Bluestone Ave

—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

62213

CERTIFICATE OF DEATH

E 62213

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

y of Baltimore: (No. Balto City Hospital St. 3-4 Ward)

2-FULL NAME James B. Bull

(a) RESIDENCE NO. 1416 Eastern St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced
HUSBAND of (or) WIFE of Charlotte Bull

DATE OF BIRTH (month, day, and year) Jan 24 1869

AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	8	15	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

BIRTHPLACE (city or town) Balto. City
(State or country)

10 NAME OF FATHER Joseph Bull

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto City

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Bernard Bull
(Address) 1322 W Lexington St

Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

0 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

11/9/1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Nov 12 1930

20 UNDERTAKER John Ulrich

ADDRESS 2115 Eutaw

—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62214

CERTIFICATE OF DEATH

E 62214

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 209 Louden Avenue St.) (Ward) 90-71

2-FULL NAME Ella V. Law

(a) RESIDENCE NO. 209 Louden Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Emory L. Law

DATE OF BIRTH (month, day, and year) October 1872

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer At Home

BIRTHPLACE (city or town) McFarland

(State or country) W. Va.

10 NAME OF FATHER Michael Lyons

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McGuire

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mr. Emory L. Law

(Address) 209 Louden Ave.

15 FILED NOV 10 1930 Registrar C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke, M. D.

Nov 8 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lowson Park Cem

DATE OF BURIAL Nov 11" 1930

20 UNDERTAKER Leopold Cook

ADDRESS 1003 N. Calvert St

3-29-28—L. F. S.—500 Bks.

Files a Ritnour

HEALTH DEPARTMENT—CITY OF BALTIMORE

62215

CERTIFICATE OF DEATH

3 VE 62215

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. 1720 Aliceana ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Jules A Ritnour

RESIDENCE NO. 1720 Aliceana ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Francis Wittmann

TE OF BIRTH (month, day, and year) 1898

Years	Months	Days	If LESS than 1 day, hrs. or min.
32	—	—	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Retired Soldier

) General nature of industry, siness, or establishment in hich employed (or employer) 056

) Name of employer Retired

RTHPLACE (city or town) tate or country)

0 NAME OF FATHER Harry Ritnaer

1 BIRTHPLACE OF FATHER (city or town) Penna.

(State or country)

2 MAIDEN NAME OF MOTHER Maria Howard

3 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

Informant Maurice Howard

(Address) 1720 Aliceana.

Filed C. HAMPSON JONES, M. D.

0 1930 By (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8-1930

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1930, to Nov. 8, 1930, that I last saw him alive on November 7, 1930 and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 12 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No Physical Signs and Symptoms

What test confirmed diagnosis?

(Signed) Samuel Silverstein, M. D.

, 19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U. S. National Cem

DATE OF BURIAL 11/11 1930

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins

8-16-29—L. F. S.—100 Bks.

62216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62216

—PLACE OF DEATH

REGISTERED NO.

Y OF BALTIMORE: (No. 2511 Guilford Avenue ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Mary A. Meise

) RESIDENCE NO. 2511 Guilford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
nale	White	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles L. Meise

TE OF BIRTH (month, day, and year)

K	Years	Months	Days	If LESS than 1 day, hrs. or min.
out	58	--	--	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work None

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Baltimore
State or country) Maryland

0 NAME OF FATHER Samuel T. Gill

1 BIRTHPLACE OF FATHER (city or town)
(State or country) West Virginia

2 MAIDEN NAME OF MOTHER Catherine Malloy

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

Informant Charles L. Meise

(Address) 2511 Guilford Avenue

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/30

17

I HEREBY CERTIFY, That I attended deceased from 11/7, 1930, to 11/8, 1930,

that I last saw h W alive on 11/8, 1930

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, aortic stenosis, cerebral embolism

6 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & Obstacle sounds

(Signed) M. D.

, 19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 11/11 19 30

20 UNDERTAKER: Henry M. Mears & Son

ADDRESS: 845 W. Lafayette

1-12 23—M&T—500 Blks.

62217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 62217

REGISTERED NO.

-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (NO. 3511 Greenspring Av. ST. 13-57 WARD)

-FULL NAME 6 mo. Fœtus Castanalgia

(a) RESIDENCE NO. 3511 Greenspring Av. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

(b) If residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	

married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11.7.30.

Years	Months	Days	If LESS than 1 day, hrs. or min.

7 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Martin Castanalgia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Bertha E. Balliet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

Informant (Address) Martin Castanalgia 3511 Greenspring Av.

Filed 1930 . 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11.8.30 19

17 I HEREBY CERTIFY, That I attended deceased from 11.7.30 to 11.8.30. 19

that I last saw h[illegible]live on 11.8.30. 19

and that death occurred, on the date stated above, at 2.- P. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Philip P. Towler M. D.

(Address) 1432 Williams St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS NOV 10 1930

20 UNDERTAKER

Commissioner Health.

8-16-29—L. F. S.—100 Bks.

E 62218

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62218

161-06

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

Y OF BALTIMORE: (No. 15 W. Lee ST. 27-30 WARD)

FULL NAME Baby boy Jones

) RESIDENCE NO. 15 W. Lee ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Black.	

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) Nov. 9, 1930

Years	Months	Days	If LESS than 1 day, hrs. or min.
½ hour.			

CUPATION OF DECEASED

) Trade, profession or rticular kind of work

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Baltimore
State or country) Md.

NAME OF FATHER Robert Wright.

1 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

2 MAIDEN NAME OF MOTHER Narcissus Jones

3 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

Informant Mother
(Address) 15 W. Lee St.

Filed ..., 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1930, to Nov. 9, 1930, that I last saw him alive on Nov. 9, 1930, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Lowey, M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL NOV 10 1930 19

ADDRESS

20 UNDERTAKER

UNIVERSITY OF MARYLAND

130—M. & T.—250 Blks.

2219 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62219

CERTIFICATE OF DEATH.

PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 76

OF BALTIMORE: (NO. Balto Md. ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Marvin Hudson

) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Black	married

narried, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year)

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

CUPATION OF DECEASED

a) Trade, profession or particular kind of work p 23

b) General nature of industry, business, or establishment in which employed (or employer) Chauffeur

c) Name of employer

RTHPLACE (city or town) (State or country) Maryland

0 NAME OF FATHER Charles Hudson

1 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

2 MAIDEN NAME OF MOTHER Elmore Mills

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Records

(Address) Balto City Hospitals

Filed 10 1930 C. HAMPSON JONES, Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-7-30

17 I HEREBY CERTIFY, That I attended deceased from 8-27-, 1930, to 11-7-, 1930.

that I last saw h[illegible]live on 11-6-, 1930

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos ds.

Tabo-Paresis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Serological

(Signed) Harry F. Corbitt, M. D.

11/7, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

UNDERTAKER Dismissed by Capitol Undertaking Co

ADDRESS 1218 McElderry St

nov 13-30

Albany Co

UNIVERSITY OF MARYLAND

1-30—M. & T.—250 Bks.

62220 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62220

CERTIFICATE OF DEATH

135

PLACE OF DEATH Baltimore City Hospitals ST. 3-4 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (NO. ST.

FULL NAME William Thorpe

) RESIDENCE NO. 670 E Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Colored	Widowed

married, widowed, or divorced
HUSBAND of
or) WIFE of Mary Thorpe

TE OF BIRTH (month, day, and year) Jan 1 1868

E Years	Months	Days	If LESS than 1 day, hrs. or min.
62	10	30	

CUPATION OF DECEASED

a) Trade, profession or particular kind of work Laborer

b) General nature of industry, business, or establishment in which employed (or employer) ? 040

c) Name of employer ?

RTHPLACE (city or town) Elizabeth City
State or country) N C

10 NAME OF FATHER Thomas Thorpe

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) N C

12 MAIDEN NAME OF MOTHER Emma McButton

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) N C

Informant Rumple Thorpe
(Address) 670 E Pratt St Baltimore City

1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5-30

17 I HEREBY CERTIFY, That I attended deceased from 10-25-, 1930, to 11-5-, 1930, that I last saw h[illegible] alive on 11-5-, 1930, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:
Benign hypertrophy of prostate

(duration) unknown ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) Fred M. Ducksall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Mausoleum DATE OF BURIAL 11/15/30

20 UNDERTAKER Jones & Jones ADDRESS 111 Eutaw St

& —100 B—50L

6221

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 E 62221

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

OF BALTIMORE: (No. Md Gen Hosp ST.) 13-59 (WARD)

FULL NAME Edw J. Poe Jr

RESIDENCE NO 3534 Sweet Air ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
White	Single

arried, widowed, or divorced
USBAND) of
or) WIFE of

E OF BIRTH (month, day, and year) 1922-

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
8			

CUPATION OF DECEASED
Trade, profession or particular kind of work School
General nature of industry, business, or establishment in which employed (or employer)
Name of employer

THPLACE (city or town) Baltimore Md
tate or country)

NAME OF FATHER Edw J Poe

BIRTHPLACE OF FATHER (city or town) Md
(State or country)

MAIDEN NAME OF MOTHER Ethel Wehr

BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

lormant Edw J Poe
(Address) 3534 Sweet Air Rd

Filed 1930 C 192 HAMPSON JONES, M. D., Registrar
By ..... Asst

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned

(duration) Sudden yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Falls Rd & Pelham Rd

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) H B Funk Coroner, M. D.

19 ..... (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Cemetery

DATE OF BURIAL Nov 11 1930

20 UNDERTAKER Chenowith & Son

ADDRESS 3610 Chestnut Ave

1-30—M. & T.—250 Bks Dr Beckley 3337 Belvedere Ave 6-5-43

62222 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62222

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. 3606 Spaulding Ave Ward 27-56

FULL NAME Cecelia Hammerslough

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

RESIDENCE NO. 3606 Spaulding Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

Sex	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

~~Married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Julian Hammerslough

DATE OF BIRTH (month, day, and year) May 3rd 1851

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	6	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER James Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Merriken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Louis Hammerslough

(Address) 3606 Spaulding Ave

Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M.

NOV 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 1930 to Nov 8 1930,

that I last saw her alive on Nov 8 1930;

and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

(duration) Uncertain yrs. mos. da.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms &c.

(Signed) G. H. Beckley, M. D.

, 19 (Address) 3337 Belvedere Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 11/11/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St. Paul st.

1-30—M. & T.—250 Bks.

62223 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62223

CERTIFICATE OF DEATH. × 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH Women's Hospital

OF BALTIMORE: (NO. 14-20 ST. WARD)

FULL NAME Bergle Schmidt

RESIDENCE NO. Catonsville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

married, widowed, or divorced HUSBAND of or) WIFE of

TE OF BIRTH (month, day, and year) April 15 1906

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	6	25	

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work Nurse

b) General nature of industry, business, or establishment in which employed (or employer) 048

c) Name of employer

RTHPLACE (city or town) State or country) London England

0 NAME OF FATHER Friedrich Schmidt

1 BIRTHPLACE OF FATHER (city or town) Berlin (State or country) Germany

2 MAIDEN NAME OF MOTHER not known

3 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Miss Winifred Bagi

(Address) 238 W. Lanvale St

C. HAMPSON JONES, M.D.

Filed 0 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Nov 10, 1930, that I last saw h[illegible] alive on Nov 10, 1930, and that death occurred, on the date stated above, at 1 AM m.

The CAUSE OF DEATH* was as follows:

Strepto coccus empyema following chest infection

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? yes Date of Nov 7 1930

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl P Clemson, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 11/11/1930

ADDRESS

20 UNDERTAKER

Mc Cook 1217 St. Paul St.

1-30—M. & T.—250 Bks

62224 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62224

CERTIFICATE OF DEATH.

REGISTERED NO. 47

PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. University Hospital WARD)

FULL NAME George W. Arnold

RESIDENCE NO. 6685 Reisterstown Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

th of residence in city or town where death occurred 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

married, widowed, or divorced HUSBAND of or) WIFE of Mary L. Arnold

TE OF BIRTH (month, day, and year) Feb 22nd 1881

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	8	17	

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work Chemist

b) General nature of industry, business, or establishment in which employed (or employer) Manufacturing

c) Name of employer Alpha Chemical Co Balto

RTHPLACE (city or town) (State or country) Md

0 NAME OF FATHER Henry Arnold

1 BIRTHPLACE OF FATHER (city or town) (State or country) On Steamer Atlantic Ocean

2 MAIDEN NAME OF MOTHER Elmira E. Schmidt

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant (Address) Mary L. Arnold 6605 Reisterstown Rd

Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 9, 1930, that I last saw him alive on Nov 9, 1930, and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

Appendicitis (Acute)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Post peritoneal appendiceal abscess & cellulitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Nov 3. 1930

Was there an autopsy? yes

What test confirmed diagnosis? autopsy & Clinical findings

(Signed) Henry S. Schmidt, M. D.

, 19 (Address) Hutzler Bros.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 11/12/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 E Paul St

-1-10-21, MAT - 1500 Blks.

62225

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

E 62225

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 430 Pittman Place (St.) 12-14 (WARD)

2-FULL NAME Lola Yvonne Par Dieu

(a) RESIDENCE NO. 430 Pittman Place St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 1st 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Charles Par Dieu

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Macie Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Charles Par Dieu 430 Pittman Place

FILED 1930 C. HAMPSON JONES, M.D. Registrar

By ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930, to Nov 8, 1930, that I last saw h[illegible] alive on Nov 8, 1930, and that death occurred, on the date stated above, at 11.55 P.m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo L. Zimmerman M.D.

11/9, 1930 (Address) 2155 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lynchburg Campbell Co. Va. DATE OF BURIAL: 11/11/1930

20 UNDERTAKER: Wm Cook ADDRESS: 1217 St Paul St

c.—1-10-21—M&T—1500 Bks.

62226

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62226

CERTIFICATE OF DEATH.

103

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 715 Rosedale St. ST. 1667 WARD)

2-FULL NAME Lewis Chester Fox

(a) RESIDENCE NO. 715 Rosedale St. ST., ... WARD .....
(Usual place of abode) V (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Ann E. Fox (nee Kraft)

DATE OF BIRTH (month, day, and year) Dec. 23, 1844

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	10	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mail Carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER George W. Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Charlotte Chester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr. Louis Fox,
(Address) 715 Rosedale St.

Filed 0 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1930, to Nov 9, 1930, that I last saw h[illegible] alive on Nov 9, 1930, and that death occurred, on the date stated above, at 4.20a m.

The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Senility ?
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) John [illegible], M. D.

19 (Address) 612 N 40 st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 11/11/30 19

20 UNDERTAKER Harry N. Witzke, 410 Edmondson ave

ADDRESS

—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62227

CERTIFICATE OF DEATH

E 62227

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

y of Baltimore: (No. Bon Secours Hospital Ward)

2-FULL NAME Mrs Mary Kestner

(a) RESIDENCE NO. 216 N Payson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 63 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 10, 1867.

AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	63	9	29	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H.W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Henry Kestner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. A. P. Krauss
(Address) 12 N. Pulaski St.

Filed ..... 19..... Registrar

NOV 10 1930 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chandler Brooke M. D.

Nov. 9 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Loudon Park

DATE OF BURIAL 11/11/30

20 UNDERTAKER Harry A. Weitzel, 410 S. Edmondson Ave

ADDRESS

1-30—M. & T.—250 Bks

62228

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62228

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 636 S. Decker av ST. WARD)

FULL NAME Francesca Scandora

RESIDENCE NO. 636 S. Decker av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

Married, widowed, or divorced (HUSBAND of or) WIFE of Sebastian Scandora

DATE OF BIRTH (month, day, and year) Sept 8th 1869

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Carmello Galliano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Francesca Scandora

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Mary Carlini

(Address) 636 S Decker av

Filed ..... 19 ..... Per ..... Registrar

C. HAMPSON JONES, M. D.

10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-or 8/30

17 ~~I HEREBY CERTIFY~~, That I attended deceased from ~~Sept 1/30~~ ..... 19 ..... to Nov 8 1930

that I last saw h alive on Nov 8 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Myocarditis

(duration) yrs 2½ mos ds.

CONTRIBUTORY (Secondary) Cystitis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) G. E. Gladfelter, M. D.

19 (Address) 1730 No Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov 12 1930

UNDERTAKER Frank V. Pistone

ADDRESS 2818 E. Baltimore st

1-12-28—MAT—500 Blks.

E 62229 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62229

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 2215 Jefferson St.

CITY OF BALTIMORE: (No.) (ST.) 6-10 (WARD)

2-FULL NAME Henry Schmid

(a) RESIDENCE NO. 2215 Jefferson ST., WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? 83 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	married

If married, widowed, or divorced (or) WIFE of Minnie Regina Schmid

6 DATE OF BIRTH (month, day, and year) Aug. 9, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	83	2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Frederick Schmid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Regina Schmid

(Address) 2215 Jefferson St

D 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to Nov. 8, 1930,

that I last saw h[illegible] alive on Nov. 8, 1930,

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic cardiac dilatation

(duration) yrs. mos 7 hrs. ds.

CONTRIBUTORY (Secondary) hypertention, chr. nephritis, arteriosclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) C. Sobital M. D.

11/8, 1930 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 11 1930
20 UNDERTAKER	ADDRESS
Mrs C. Miller & Son	2334 E. Fayette St

& T.—100 B—50L

62230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 E 62230

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

OF BALTIMORE: (No.) St. Joseph Hospital ST., 710 WARD)

FULL NAME Maria A. Gross

RESIDENCE NO 2248 McElderry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	white	married

rried, widowed, or divorced
USBAND of
r) WIFE of William Gross

E OF BIRTH (month, day, and year) Sep 2/1889

Years	Months	Days	If LESS than 1 day, hrs. or min.
41	2	6	

UPATION OF DECEASED
Trade, profession or
ticular kind of work
General nature of industry,
siness, or establishment in
hich employed (or employer)
Housework
At home

Name of employer

THPLACE (city or town)
tate or country) Balto., Md.

NAME OF FATHER Onlander Larkin

BIRTHPLACE OF FATHER (city Balto., Md.
(State or country)

MAIDEN NAME OF MOTHER Mary Caper

BIRTHPLACE OF MOTHER (city Penna.
(State or country)

Informant Marie Schmidt
(Address) 2248 McElderry st

1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pulmonary Embolism
Cardio-Renal Disease- Ascites

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of Nov 8/30

Was there an autopsy? no Paracentesis

What test confirmed diagnosis?

(Signed) ..... Coroner, M. D.

Nov 10/30 (Address) 20 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL Nov. 14 1930

20 UNDERTAKER Mrs. L. Miller & Son

ADDRESS 2334 Jefferson Av.

2-29-28—L. F. S.—500 Bks.

62231

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62231

CERTIFICATE OF DEATH

9.0

PLACE OF DEATH

OF BALTIMORE: (No.) Md. General Hospital ST. WARD) 13-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Mrs. Ida Mollie mondawmin ave

RESIDENCE NO. 2303 Meadowman ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

of residence in city or town where death occurred Left mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

E OF BIRTH (month, day, and ye July 12, 1849

Years	Months	Days	If LESS than 1 day, hrs. or min.
81		27	

UPATION OF DECEASED

Trade, profession or ticular kind of work: Retired

General nature of industry, iness, or establishment in ich employed (or employer)

Name of employer

THPLACE (city or town) tate or country): Baltimore Md

NAME OF FATHER Geo Mollie

BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

MAIDEN NAME OF MOTHER Suzanne Moore

BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

Informant: Hospital Record

(Address)

1930 — 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-19-, 1930, to Nov 9, 1930, that I last saw h[er] alive on November 9, 1930 and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (with decompensation)

(duration) 1? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 2 ds.?

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Robert L. Chisum, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Nov 11 1930

20 UNDERTAKER: John O. Mitchell & Sons. — ADDRESS: 19 E Eutaw Place

—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 62232

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 62232

1-PLACE OF DEATH: (No.) St Joseph Hosp St. 8-17 Ward)

of Baltimore:

2-FULL NAME Thos A Gordon

(a) RESIDENCE NO. 710 Llewlyn St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced: HUSBAND of (or) WIFE of Mary McGorley

DATE OF BIRTH (month, day, and year) 12/21/1894

AGE	Years	Months	Days	IF LESS than 1 day: hrs. or min.
	35	10	2	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

BIRTHPLACE (city or town) Balto Md
(State or country)

10 NAME OF FATHER Chas Gordon

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary - Don't know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant (Address)

15 Filed 11 1930 C. HARRISON GILL, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck and knocked down by moving auto truck near pedestrian Disease

(a) Fract Skull (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bond & Edw'y

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. L. Frame M. D.

11 11 1930 (Address) 1139 W. Edwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: 11 - 11 1930

ADDRESS

20 UNDERTAKER: George J Ruth Inc 1135 Hartford

1-30—M. & T.—250 Bks.

62233

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 62233

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 616 W McCulloh St. 14-20 WARD

FULL NAME Shirley Mae Keys

RESIDENCE NO. 616 W McCulloh St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	ca	Infant

Married, widowed, or divorced
(If HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 2-30

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Theodore Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eva Yochey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Theodore Keys

(Address) 616 W McCulloh St

11930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9-30

17 I HEREBY CERTIFY, That I attended deceased from 11-7-30, 19..., to 11-9, 19 30.

that I last saw h... alive on 11-9, 19 30

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Beverly Butler, M. D.

, 19 (Address) 425 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 11/11 19 30

ADDRESS

20 UNDERTAKER Mrs. Geo. H. Holland 1631 Druid Hill

1-30—M. & T.—250 Bks.

62234

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 62234

CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 527 S. Brunswick St. WARD) 19-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Charles H. Sands

RESIDENCE NO. 527 S. Brunswick St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(If married, widowed, or divorced) (HUSBAND of or) WIFE of Anna T. Sands

6 DATE OF BIRTH (month, day, and year) Mar 9th 1874

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	29	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer Ferry Company

8 BIRTHPLACE (city or town) (State or country) Norfolk, Va

9 NAME OF FATHER W. S. Sands

10 BIRTHPLACE OF FATHER (city or town) (State or country) Va

11 MAIDEN NAME OF MOTHER Lucie Mewis

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Anna T. Sands

(Address) 527 Brunswick

Filed NOV 11 1930

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930 to Nov 8th, 1930

that I last saw h alive on Nov 8th, 1930

and that death occurred, on the date stated above, at 1.20 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Chas A Ehrman, M. D.

10, 1930 (Address) 2145 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 8th 1930

20 UNDERTAKER H. S. Nesbit — ADDRESS 1850 N Balto St

-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 62235

62235 REGISTERED NO.

PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No.) 1722 N. Bradford ST. 8-16 WARD)

FULL NAME Edward L. Bromwell

RESIDENCE NO. 1722 N. Bradford ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred 39 yrs. 10 mos. 8 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

narried, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

E OF BIRTH (month, day, and year) Jan 1 1891

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39	10	8	

CUPATION OF DECEASED

) Trade, profession or particular kind of work Chauffeur

) General nature of industry, business, or establishment in which employed (or employer) 623

) Name of employer

RTHPLACE (city or town) Baltimore
State or country)

NAME OF FATHER Samuel Bromwell

1 BIRTHPLACE OF FATHER (city or town) Not known
(State or country)

2 MAIDEN NAME OF MOTHER Kate Cook

3 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

Informant Mrs Kate Bromwell
(Address) 1722 N. Bradford

Filed 11 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1930

17 I HEREBY CERTIFY, that I attended deceased from March, 1926, to Nov 9, 1930, that I last saw h[illegible] alive on Nov 9, 1930, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Heart Failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. F. Engel, M. D.

11/9/30 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 12 1930

20 UNDERTAKER Henry Lutz — ADDRESS 1203 N Broadway

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 62236

62236

CERTIFICATE OF DEATH.

REGISTERED NO.

PLACE OF DEATH Jenkins Memorial Hospital

OF BALTIMORE: (No. 1000 Caton Ave ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Michael F. Creaghan

RESIDENCE NO. 340 Cabenahan Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

Married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kelly

DATE OF BIRTH (month, day, and year) Aug 15 / 1834

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	96	2	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Farmer.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Thos Creaghan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Jenkins Memorial Hosp

(Address) 1000 Caton Ave

Filed Nov 13, 1930

C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930, to Nov 10, 1930, that I last saw him alive on Nov 10, 1930, and that death occurred, on the date stated above, at 3:500 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 4 da. (?)

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hilmar S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

UNDERTAKER John J Fahey Sons

DATE OF BURIAL 11/13 1930

ADDRESS 1318 Eutaw St

& T.—100 B—50L

62237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

22 ✓ E 62237

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH
OF BALTIMORE: (Not) En route to University Hospital WARD 17324

FULL NAME Mozel Showers

RESIDENCE NO 1225 Myrtle Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	Colord	Single

arried, widowed, or divorced
USBAND of
r) WIFE of ✗

E OF BIRTH (month, day, and year) March 11 1928

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	7	29	

CUPATION OF DECEASED
Trade, profession or
rticular kind of work None
General nature of industry,
siness, or establishment in
hich employed (or employer)
Name of employer

THPLACE (city or town)
tate or country) Alabama

NAME OF FATHER Moses Showers

BIRTHPLACE OF FATHER (city or town)
(State or country) Ga

MAIDEN NAME OF MOTHER Fannie Williams

BIRTHPLACE OF MOTHER (city or town)
(State or country) Ga

nformant Frank Showers

(Address) 1225 Myrtle Ave

Filed 1930 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Anterior Poliomyelitis

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zollers Coroner, M. D.

11/11, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lak Calvary Cem

DATE OF BURIAL Nov 13 1930

20 UNDERTAKER Samuel Hensley

ADDRESS 711 Bdle St

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

62238

CERTIFICATE OF DEATH.

16-23

129 E 62238

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 1123 Woodyear S. 16-23 WARD)

FULL NAME Emma Jackson

RESIDENCE NO. 1123 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Widowed

Married, widowed, or divorced (HUSBAND) of (or) WIFE of Samuel Jackson

DATE OF BIRTH (month, day, and year)

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

BIRTHPLACE (city or town) (State or country) West river Md

10 NAME OF FATHER Osborne Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westriver Md

12 MAIDEN NAME OF MOTHER Phylis Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West river Md

Informant Ruth Cooper

(Address) 1123 Woodyear St.

File 11 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-1, 1930, to 11-5, 1930,

that I last saw her alive on 11-5, 1930,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) myocarditis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. and Microscopical Exam

(Signed) Samuel Saunders, M. D.

11-9-, 1930 (Address) 1229 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11/11 1930

20 UNDERTAKER Samuel Hansley

ADDRESS 1278 Bridge

1-30—M. & T.—250 Bks

E 62239 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62239

CERTIFICATE OF DEATH. 129

PLACE OF DEATH Baltimo e City Hospitals ST. 21-55 REGISTERED NO.

OF BALTIMORE: (NO. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Upton Tylor

RESIDENCE NO. 5416 Denmore Ave. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced
(or) HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Suburban Club-Pikesville

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Basil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. ?

12 MAIDEN NAME OF MOTHER Alice Munroe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of
(Address) Balto. City Hosp.

Filed 11 1930 By C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9-30

17 I HEREBY CERTIFY, That I attended deceased from 11-6-30, 19..., to 11-9-30, 19...,

that I last saw h i alive on 11-9-30, 19...,

and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, with oedema

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uremia, acute

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padgett, M. D.

11-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 11/12 1930

20 UNDERTAKER Samuel Wensley

ADDRESS 1778 Edmondson Ave

9-30—A. & Co.—250 Bks.

E 62240

62240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE (No. 1744 Ashland Ave ST. 713 WARD)

FULL NAME Carl Ellis Evans

(a) RESIDENCE NO. 1744 Ashland Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 14 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Chas L Evans

6 DATE OF BIRTH (month, day, and year) Feb 22 - 1892

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8	16	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Richmond Va

9 NAME OF FATHER Unknown

10 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

11 MAIDEN NAME OF MOTHER Unknown

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Chas L Evans

(Address) 1744 Ashland Ave

Filed Nov 10 1930 THOMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 - 1930

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 8, 1930

that I last saw h alive on 9:30 AM

and that death occurred, on the date stated above, at 9:30 AM

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. F. Finan M. D.

1931 (Address) 713 S Broadway

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem

DATE OF BURIAL 11/11 1930

ADDRESS

20 UNDERTAKER Samuel Hemsley

ADDRESS 1701 Biddle

1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 E 62241

PLACE OF DEATH

OF BALTIMORE: (No. 1015 S. Bayliss ST. 26-37 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Henry Deickman

RESIDENCE NO. 1015 S. Bayliss ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
le	White	Married

Married, widowed, or divorced (HUSBAND of (or) WIFE of) Minnie Deickman

6 DATE OF BIRTH (month, day, and year) Feb. 25 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	8	11	13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roll-Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Copper M. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Ernest Deickman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

Informant Minnie Deickman

(Address) 1015 S. Bayliss St.

Filed 1930 C. Hargrove Johns, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Octob. 20 1930 to Nov. 8 1930

that I last saw him alive on Nov. 8 1930

and that death occurred, on the date stated above, at 8P. M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

2 weeks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris. Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at the place of work

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physicans Examin.

(Signed) Jos. A. Rosenblatt, M. D.

11/10 1930 (Address) 3018 O'Donnell St., Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Cemetery

DATE OF BURIAL Nov 11 1930

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager st

30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE E 62242

62242

CERTIFICATE OF DEATH.

44

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. 1626 E. Lanvale ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Frank E. Bertermann

RESIDENCE NO. 1626 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
le	White	Widowed

narried, widowed, or divorced HUSBAND of or) WIFE of Elizabeth E. Bertermann

TE OF BIRTH (month, day, and year) Oct. 6 1861

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	1	4	

CUPATION OF DECEASED

a) Trade, profession or particular kind of work Baker (Retired)

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) (State or country) Frederick, Md.

0 NAME OF FATHER John Bertermann

1 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Henriette Lampe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Frank C. Bertermann, Jr.

(Address) 1626 E. Lanvale St

Filed NOV 11 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1930

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to Nov 10, 1930, that I last saw him alive on Nov 9, 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Gastric)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallace W. White Jr. M. D.

Nov 10, 1930 (Address) 2800 Ft Pundell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Nov. 13 1930

20 UNDERTAKER George W. Zinkler — ADDRESS 1737 E. Eager St

1-30—M. & T.—250 Bks

62243

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62243

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. 1104 S. Robinson ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME John W. Fritchman

RESIDENCE NO. 1104 S. Robinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Widowed

Married, widowed, or divorced (HUSBAND of (or) WIFE of) Mary C. Fritchman

DATE OF BIRTH (month, day, and year) June 8 1852

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	5	-	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman (Pensioned)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Greensboro, Penna.

10 NAME OF FATHER John Fritchman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Susanna Butz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

Informant Miss Dollie Fritchman

(Address) 1104 S. Robinson St.

Filed 11 1930 19 C. Hunson Jones, M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 5-th, 1930, to 8th, 1930,

that I last saw h[illegible] alive on Nov. 8th, 1930,

and that death occurred, on the date stated above, at 9 P.M.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) - yrs. - mos 5 ds.

CONTRIBUTORY (Secondary) arterio Sclerosis

(duration) 3 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) David M. Jones, M. D.

11/10, 1930 (Address) 1011 N. Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL Nov 12 1930

20 UNDERTAKER George W. Zipkin

ADDRESS 1737 E. Eager St

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62244

23 E 62244

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) 2425-N-Calvert ST. 12-50 (WARD)

FULL NAME Perry Auld Bailey

RESIDENCE NO. 2425-N-Calvert ST. 12 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	Married

(If married, widowed, or divorced) HUSBAND of (or) WIFE of Catherine Hamilton Bailey

DATE OF BIRTH (month, day, and year) about May 1885

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 45	6	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

BIRTHPLACE (city or town) (State or country) Washington D.C.

10 NAME OF FATHER Josiah R. Bailey

11 BIRTHPLACE OF FATHER (city or town) Butts. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Libbie Brawner

13 BIRTHPLACE OF MOTHER (city or town) Butts. (State or country) Maryland.

Informant Mrs. Marion R. Bailey (Bro)

(Address) Stoneleigh-Md

Filed NOV 11 AON. H. Hudson Jones, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10/1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1927 to November 10, 1930, that I last saw h[illegible] alive on November 10, 1930, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Paralysis of cardio respiratory centers (duration) 1 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Grover M. Bruce M. D.

11/1, 1931 (Address) 1435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Nov 12 1930.

20 UNDERTAKER Stewart & Co. — ADDRESS Baltimore

E 62245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 62245

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

OF BALTIMORE: (No. 5715 Seymour Ave. Respeburg ST. 27-45 WARD)

FULL NAME Pearl Elizabeth Hauser

RESIDENCE NO. 5715 Seymour Ave. Respeburg ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
White	----------

10 ...rried, widowed, or divorced
...USBAND of
...r) WIFE of ----------

E OF BIRTH (month, day, and year) Jan. 5 1930

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
0	10	5	

...UPATION OF DECEASED
...Trade, profession or ...ticular kind of work
...General nature of industry, ...siness, or establishment in ...ich employed (or employer)
Infant

Name of employer

...THPLACE (city or town) Balto.
...ate or country) Maryland

NAME OF FATHER Milton J. Hauser

BIRTHPLACE OF FATHER (city or town) Chicago
(State or country) Illinois

MAIDEN NAME OF MOTHER Bessie G. Seymour

BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

...rmant Bessie G. Seymour Hauser
(Address) 5715 Seymour Ave. Respeburg

Filed ..... G. HALPERSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inqdest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5? ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. H. Waters, M. D. Coroner

Nov 12 1930 (Address) 508 E. ...orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Nov. 11 19 30

20 UNDERTAKER Frederick Lissade & Sons — ADDRESS 7401 Belair Rd.

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62246

CERTIFICATE OF DEATH.

62246

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH
OF BALTIMORE: (NO. 115 N. East Ave ST. No 11 WARD)

FULL NAME Mary E. Stall

RESIDENCE NO. 115 N. East Ave ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

6 If married, widowed, or divorced
(If) HUSBAND of
(or) WIFE of Jos. H. Stall

7 DATE OF BIRTH (month, day, and year) Mar 9/1837

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	93	7	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Wm Marsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eliz. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

Informant Mrs Emma Wills
(Address) 115 N. East Ave

Filed 1-1 1930 C. HAMPSON JONES, M. D. Registrar
Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1930, to Nov 8, 1930, that I last saw h[illegible] alive on Nov 7 1930 and that death occurred, on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows: Valvular Heart Disease

(duration) 1 yrs. _____ mos _____ ds.

CONTRIBUTORY (Secondary) Old age

(duration) _____ yrs. 2 mos. 4 ds.

Bronchitis

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Hearn M. D.

11/10, 1930 (Address) 2901 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 11 1930

UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62247 — 90 E 62247 — REGISTERED NO.

PLACE OF DEATH

Y OF BALTIMORE: (No. 28 E. Lanvale ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Eyeonia Hurt

) RESIDENCE NO. 28 E. Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

h of residence in city or town where death occurred 6/ yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: female white

5 Single, Married, Widowed, or Divorced, (write the word): Single

married, widowed, or divorced HUSBAND of (or) WIFE of —

TE OF BIRTH (month, day, and year) April 11-1852

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
78	6	30	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work: Dress Maker

) General nature of industry, siness, or establishment in hich employed (or employer): Self

) Name of employer

BIRTHPLACE (city or town) State or country): Va

0 NAME OF FATHER Edwin Harrison Hurt

1 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

2 MAIDEN NAME OF MOTHER Mary S. Bowden

3 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

Informant Letitia Hurt

(Address) 28 E. Lanvale

C. HARRISON JONES, M. D.

Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1930, to Nov 10, 1930, that I last saw h. ev alive on Nov 10, 1930 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ch. Valv. Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Howard Ruff, M. D.

11/11. 1930 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Nov. 12 1930

20 UNDERTAKER: Chas. E. Franch ADDRESS: 801 Madison ave

M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 ✓ E 62248

62248

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 1117 Thompson St ST., 5-8 WARD)

2-FULL NAME William Coleman

(a) RESIDENCE NO 1117 Thompson St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 8 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	black	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) 1898

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Washington, D.C.

10 NAME OF FATHER John Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Warner

13 BIRTHPLACE OF MOTHER Md. (city or town) (State or country)

Informant Melvina Jackson
(Address) 1117 Thompson St

Filed ..... 192 ..... (Registrar.)

11 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov8/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Cardiac Insufficiency.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes - Dr. Maldeis

What test confirmed diagnosis? .....

(Signed) John H. Caine Coroner, M. D.

Nov 10/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 11-11 1930

UNDERTAKER Byron Wright 1218 Mc Elderry St

ADDRESS

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62249

2249

CERTIFICATE OF DEATH.

118-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. University Hosp 22-30 ST., WARD)

FULL NAME Robert Oehm

RESIDENCE NO. 686 Wash. Blvd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	White	Single

If married, widowed, or divorced
(HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) March 21 1876

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	6	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Winchester Va.

NAME OF FATHER Francis H. Oehm.

BIRTHPLACE OF FATHER (city or town) (State or country) Va.

MAIDEN NAME OF MOTHER Wm. Bond

BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant Ernest A Oehm.

(Address) 676 Wash. Blvd.

Filed 11 1930 H. Hartzog Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8-30.

17 I HEREBY CERTIFY, That I attended deceased from 11-2-30, 19 to 11-8-30, 19

that I last saw him alive on 11-8-30, 19

and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Left Scrotal Hernia

(duration) 33 yrs. mos da.

CONTRIBUTORY (Secondary) Incomplete Int. Obstruction; Peritonitis Hypostatic Pneumonia

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-4-30

Was there an autopsy? No

What test confirmed diagnosis? Phys. Signs

(Signed) Henry J. Peard, M. D.

11/8/19 30 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 11-11 1930

20 UNDERTAKER Bernard C Harle 1000

ADDRESS S Paca St.

c—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62250 100-001 E 62250

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 211 S. Pulaski St. (Ward) 20-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Wm. Ballenstedt

(a) Residence No. 211 S. Pulaski St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of Margaret Ballenstedt

DATE OF BIRTH (month, day and year) Dec 14 1868

If LESS than 1 day, ...hrs. or.....min.

AGE 61 yrs. 10 mos. 25 ds.

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mould maker

(b) General nature of industry, business, or establishment in which employed (or employer) for Glassware

(c) Name of employer.....

BIRTHPLACE (city or town) (State or Country). New Jersey

10-NAME OF FATHER. William Ballenstedt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Von Lossen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

I-(Informant) Mrs. Margaret A. Ballenstedt

(Address) 211 S. Pulaski St.

15-Filed NOV 11 1930 C. HARRISON JONES, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 9-1930

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1930 to Nov 9 1930

That I last saw h.. alive on Nov 9 1930

and that death occurred, on the date stated above, at 7 40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Stella Henning M. D.

11/11 1930 Address) 2000 Holland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL. Nov. 12 1930

20-UNDERTAKER George L. Schwab ADDRESS 210 Fredrick Ave

2-29-28—L. F. S.—500 Bks.

62251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 62251

REGISTERED NO.

PLACE OF DEATH Franklin Square Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. 18-26 STREET) WARD

FULL NAME Louis Vogel

RESIDENCE NO. 817 W Saratoga St

(If non-resident give city or town and State)

(Usual place of abode)

of residence in city or town where death occurred 4 yrs. 5 mos. 6 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) March 4 1883

Years	Months	Days	If LESS than 1 day, hrs. or min.
47	8	6	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Painter

) General nature of industry, siness, or establishment in hich employed (or employer) House Painter

) Name of employer

RTHPLACE (city or town) Baltimore
State or country) Md

0 NAME OF FATHER Weigand Vogel

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

2 MAIDEN NAME OF MOTHER Pauline Emerling

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Weigand Vogel
(Address) 817 W Saratoga

Filed 11 1930, 19 [illegible] JONES, H. S.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-7, 1930, to 11-10, 1930

that I last saw h alive on 11-10, 1930

and that death occurred, on the date stated above, at 10:00 A m.

The CAUSE OF DEATH* was as follows:

Blood & Cerebro spinal Lues

Fuetus Cardio Vascular disease

(duration) 5 yrs.? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Partial

What test confirmed diagnosis? Clinical & Laboratory

(Signed) C. W. Fegan, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Nov 12 1930

20 UNDERTAKER J Vernon Keehner — ADDRESS 53 Hollins

—10-10-29—A Co.—100 Bks.

E 62252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-002

E 62252

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH M.E. Home for the Aged

y of Baltimore: (No. 400 N. Fulton St., 20 Ward)

2-FULL NAME Miss Josephine Rider

(a) RESIDENCE NO. 400 N. Fulton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Fmale	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 29 1843

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	87	1	20	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Md
(State or country)

10 NAME OF FATHER Thos Rider

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Collins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Delaware

14 Informant Ella Cridler
(Address) 400 N Fulton

Filed NOV 11 1930 C. H. Pool Jones, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture L F W

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Brooke M. D.

Nov 10 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 12 1930
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

—9 30—A. & Co.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62253

CERTIFICATE OF DEATH.

E 62253

104-002

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No 2238 Barclay ST. 12-50 WARD)

2. FULL NAME Charles W. Houck

(a) RESIDENCE NO. 2238 Barclay ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos ds. How Long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Agnes E. Houck

6. DATE OF BIRTH (month, day, and year) May 18th 1895

7. AGE. Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	4	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Baltimore, Md

10. NAME OF FATHER Charles H. Houck

11. BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12. MAIDEN NAME OF MOTHER Bertha M. Fenn

13. BIRTHPLACE OF MOTHER (city or town) (State or country) Fairfield Md

Informant (Address) Mrs Agnes E Houck 2238 Barclay st

Filed 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) Nov 9, 1930

17. I HEREBY CERTIFY, That I attended deceased from October 31, 1930, to Nov 9th, 1930

that I last saw h[illegible] alive on Nov 9th 1930

and that death occurred, on the date stated above, at 3.10 P m.

The CAUSE OF DEATH* was as follows:

Streptococci Infected Throat

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic Poison

(duration) yrs. mos. 20 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S. Towns M.D. M. D.

, 19 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov. 12 1930

20. UNDERTAKER Mary M. Waddell

ADDRESS 601 E 32nd St

M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62254

90 E 62254

CERTIFICATE OF DEATH

REGISTERED NO. 24-35

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 1418 Hull St. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simon Mackwicz.

(a) RESIDENCE NO 1418 Hull St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

DATE OF BIRTH (month, day, and year) December 15, 1882

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	10	25	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Poland.

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know.

Informant: Marion Mack.

(Address) 1418 Hull St.

Filed NOV 11 1930 HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 9, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra ventricular Cerebral Hemorrhage
Chronic Valvulitis
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & inquest

(Signed) Otto M. Reinhardt, M. D. Coroner

11/11 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross R.C. Cem.

DATE OF BURIAL: Nov 12 1930

20 UNDERTAKER: Charles L. Burns

ADDRESS 1157 E Fort

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62255

CERTIFICATE OF DEATH.

100-001 V

E 62255

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. Sinai Hospital ST., 13 WARD)

FULL NAME Dolores Elizabeth Schroll

) RESIDENCE NO. 648 S Belnord ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	single

Married, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year) Oct 9 1930

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	1	

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) (State or country) Baltimore Md

0 NAME OF FATHER James Schroll

1 BIRTHPLACE OF FATHER (city or town) Balto, md (State or country)

2 MAIDEN NAME OF MOTHER Elizabeth Mruk

3 BIRTHPLACE OF MOTHER (city or town) Balto md (State or country)

Informant Sinai Hospital (Address)

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1930, to Nov. 10, 1930,

that I last saw her alive on Nov 10, 1930,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, hypostatic

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Obs

(Signed) Milton Blum, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery — DATE OF BURIAL Nov 11 1930

20 UNDERTAKER George A. Weber — ADDRESS 705 S. Ann St.

NOV 11 1930 HARRY C. JONES, M. D. Registrar

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62256 81 E 62256

REGISTERED NO. 12-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—PLACE OF DEATH

Y OF BALTIMORE: (No. 512 S. Washington St. ST., WARD)

—FULL NAME Wladyslaw Truszkowski

) RESIDENCE NO. 512 S. Washington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	White	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis Truszkowski

TE OF BIRTH (month, day, and year) ?

Years	Months	Days	If LESS than 1 day, hrs. or min.
64			

CUPATION OF DECEASED

) Trade, profession or particular kind of work Stevedore

) General nature of industry, siness, or establishment in hich employed (or employer) 074

) Name of employer

RTHPLACE (city or town) (State or country) Poland

0 NAME OF FATHER Stanly Truszkowski

1 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

2 MAIDEN NAME OF MOTHER Monikowska

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant F. Truszkowski

(Address) 512 S. Washington St.

Filed 11 1936 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-12-30, 19..., to 11-10, 1930, that I last saw h[illegible] alive on Oct 12, 1930 and that death occurred, on the date stated above, at 3 A.m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

1 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Rheumatism (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Geo Heller, M. D.

11-10, 1930 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Nov 12 1930

20 UNDERTAKER P. W. Czazewski 1930 ADDRESS Eastern Av

-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62257 — 57 — E 62257

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. 716 W. Fayette ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Frederica Feldpush

RESIDENCE NO. 716 W. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
White	married

...married, widowed, or divorced
...Wife of George Feldpush

E OF BIRTH (month, day, and year) Mar. 23, 1863

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
67	7	16	

UPATION OF DECEASED

Trade, profession or ticular kind of work None.

General nature of industry, iness, or establishment in ich employed (or employer)

Name of employer

RTHPLACE (city or town) Balto., Md.
(State or country)

NAME OF FATHER Ferdinand Mardaga

BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

MAIDEN NAME OF MOTHER Christina Pullar

BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

Informant George Feldpush - Husband
(Address) 716 W. Fayette St.

Filed ... 19 ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9-30

17 I HEREBY CERTIFY, That I attended deceased from 3-3-, 1926, to 11-9-, 1930, that I last saw h W alive on 11-9-, 1930 and that death occurred, on the date stated above, at 10 50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 4 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/20/30

Was there an autopsy? No Physical Evidence

What test confirmed diagnosis?

(Signed) Geo. B. Dyberk, M. D.

19 (Address) 2802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11 12 1930

20 UNDERTAKER Edw. Foreman & Co.

ADDRESS 2339 Wash Ave

11 1930 ... Department.

1-30—M. & T.—250 Bks.

E 62258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62258

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) 619 W. Franklin ST. 17-25 (WARD)

FULL NAME Frank C. O'Neil

) RESIDENCE NO. 619 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	Widowed

married, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year) Unknown

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 58			

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work Bldg. Supplies Broker

b) General nature of industry, business, or establishment in which employed (or employer) Bldg. Supplies

c) Name of employer Self

RTHPLACE (city or town) Unknown
State or country) Unknown

0 NAME OF FATHER Unknown

1 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Robert R. Riley
(Address) 619 W. Franklin St Balto Md

Filed 11 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28th, 1930, to Nov. 11th, 1930,

that I last saw him alive on November 10th, 1930,

and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) 1 yrs. mos ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Nov. 23rd 1929

Was there an autopsy? No

What test confirmed diagnosis? Johns Hopkins Hospital Records

(Signed) Edward G. Reigart M. D.

11th, 1930 (Address) 2221 N. Fulton Av. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oklahoma City Okla

DATE OF BURIAL Nov 14 1930

20 UNDERTAKER Wm J Tucker & Sons

ADDRESS North st

& T.—100 B—50L

62259

E 62259

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

OF BALTIMORE: (No.) 765 W. Lexington ST., 18-26 (WARD)

FULL NAME Harry ~~Howard~~ B. Warden

RESIDENCE NO 765 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
le	White	Unknown

rried, widowed, or divorced
USBAND) of
r) WIFE of

E OF BIRTH (month, day, and year) June 5-1875

Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
55	5		

UPATION OF DECEASED
Trade, profession or ticular kind of work Laborer
General nature of industry, siness, or establishment in hich employed (or employer) 040

Name of employer

THPLACE (city or town) tate or country) Conn

NAME OF FATHER Warden

BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Normant U.S. Veterans Bureau

(Address) Fort McHenry, Md.

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoned by illuminating gas. Probably Suicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Stitely Coroner, M. D.

11/11. 19 30 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwich, Conn

20 UNDERTAKER Harry K. Mitzke, 41

DATE OF BURIAL 11/11/30

ADDRESS 616 Edmondson Ave

29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62260 — 90 E 62260

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. 631 McHenry Ave ST., 9-46 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME B Agnes Rocap.

RESIDENCE NO. 631 McHenry Ave ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

How long in U. S., if foreign birth? yrs. mos. ds.

of residence in city or town where death occurred 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced (HUSBAND of (or) WIFE of) Harry E. Rocap

7 DATE OF BIRTH (month, day, and year) Apr 7 1876

Years	Months	Days	If LESS than 1 day, hrs. or min.
54	7	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co.

10 NAME OF FATHER Pr P. McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Harry E. Rocap

(Address) 631 Mc Henry Ave

Filed Dec 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 1930, to Nov 9 1930,

that I last saw her alive on Nov 9 1930,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L Dr C. Carter, M. D.

11/10, 1930 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Joseph's Cem Texas Md

DATE OF BURIAL Nov 12 1930

20 UNDERTAKER Rita Mendfeld 914

ADDRESS Greenmount Ave

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

62261

CERTIFICATE OF DEATH.

202

E 62261

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. University Hospital St. 6-70 WARD)

FULL NAME Rosalie V. McLaughlin

RESIDENCE NO. 631 Linware ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	married

married, widowed, or divorced HUSBAND of (or) WIFE of Jos. B. McLaughlin

DATE OF BIRTH (month, day, and year) Unknown

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 63			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Henry Burroughs Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N J

12 MAIDEN NAME OF MOTHER Mary Patterson Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N J

Informant Augustus M. McLaughlin

(Address) 2118 Shelburne Rd

Filed DEC 12 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10/30

17 I HEREBY CERTIFY, That I attended deceased from 11/7, 1930, to 11/10, 1930,

that I last saw her alive on 11/9/, 1930,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows: Infected finger left hand.

Acute Cardiac Failure

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/8/30

Was there an autopsy? No Ambulatory Patient

What test confirmed diagnosis? Clinical Examination

(Signed) George Yeager, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Nov 12, 30

UNDERTAKER Wm J Tickner & Son

ADDRESS N. Y. Pa

10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62262

CERTIFICATE OF DEATH

188-103

E 62262

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH: (a) of Baltimore: (No. Union Mem Hosp St., 12-50 Ward)

2-FULL NAME Stephen J. Conroy

(a) RESIDENCE NO. 323½ Lorraine Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Ellen Conroy

DATE OF BIRTH (month, day, and year) June 29 1870

AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60	4	9	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman Water
(b) General nature of industry, business, or establishment in which employed (or employer) Dept. Balto City
(c) Name of employer Md.

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER John Conroy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Toole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ellen Conroy
(Address) 323½ Lorraine Av

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck and Knocked Down by moving auto

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Chas & 27th

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Fraine, M. D.

11. 1930 (Address) 2939 W Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 11-12 1930

20 UNDERTAKER J. A. Inoran

ADDRESS 3000 E Baltimore

1-30—M. & T.—250 Bks.

62263

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62263

CERTIFICATE OF DEATH.

62263

11-24 90

PLACE OF DEATH

OF BALTIMORE: (No. 309 Dolphin ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME George Heath Doll

RESIDENCE NO. 309 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	married

arried, widowed, or divorced
USBAND of
~~e) Widow~~ Eva L. Doll

E OF BIRTH (month, day, and year) Aug. 20 1867

Years	Months	Days	If LESS than 1 day, hrs. or min.
3	2	20	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work expert accountant

) General nature of industry, siness, or establishment in hich employed (or employer) 809

) Name of employer E. R. Bradley Estate

THPLACE (city or town) tate or country) Michigan.

NAME OF FATHER George Doll

BIRTHPLACE OF FATHER (city or town) Sydney

(State or country) Ohio

2 MAIDEN NAME OF MOTHER Sarah Ramsay

3 BIRTHPLACE OF MOTHER (city or town) Springfield

(State or country) Ohio

Informant Mrs. M. Shirts.

(Address) 608 Cambridge Pl. Pewee Point

Filed NOV 12 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from

about 2 yrs, 19 prior to Nov. 10, 1930,

that I last saw h/m alive on Nov. 10, 1930,

and that death occurred, on the date stated above, at 9.20 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

Insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation (duration) [illegible] mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John T. King Jr. M. D.

Nov. 10, 1930 (Address) 219 W. Lanvale St Baltimore, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Detroit Michigan

DATE OF BURIAL 11-13 1930

20 UNDERTAKER Henry W. Jenkins' Sons Co

ADDRESS Orchard & McCulloh

8-16-29 L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62264

CERTIFICATE OF DEATH

73

E 62264

REGISTERED NO.

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. 414 Bretton Place ST., 12-49 WARD)

FULL NAME Miss Margaret Ann Strong

RESIDENCE NO. 414 Bretton Place ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 1 mos. 0 ds. How long in U. S., if foreign birth 41 yrs. 1 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Single

Married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) November 5, 1852

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	0	5	

OCCUPATION OF DECEASED

a) Trade, profession or particular kind of work None

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) (State or country) Granard Co. Longford, Ireland

NAME OF FATHER William Strong

BIRTHPLACE OF FATHER (city or town) Granard
(State or country) Co Longford, Ireland

MAIDEN NAME OF MOTHER Ann Burroughs

BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

Informant Miss Violet Strong

(Address) 414 Bretton Place

Filed NOV 12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to Nov. 10, 1930,

that I last saw h[illegible] alive on Nov 10, 1930

and that death occurred, on the date stated above, at abt 6 P. m.

The CAUSE OF DEATH* was as follows:

Progressive Central muscular atrophy (senile type)

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Jno A Kutscher, M. D.

11/11. 1930 (Address) 12 Wagner Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park Cem — DATE OF BURIAL Nov 12 1930

20 UNDERTAKER Henry Heuisler & Son Co — ADDRESS Orleans & Collington Sts

NOV 12 1930

M. & T.—100 B—50L

E 62265

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-002 ✓

REGISTERED NO. E 62265

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 S. Howard St. ST. 23-31 WARD)

2-FULL NAME Ruth V. Brown. (C)

(a) RESIDENCE NO 1003 S. Howard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

DATE OF BIRTH (month, day, and year) September 25, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	1	16	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER William Brown. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 ~~MAIDEN~~ NAME OF MOTHER Ethel Johnson. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

Informant Ethel Johnson. (C) mother.

(Address) 1003 S. Howard St.

Registrar

NOV 12

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 11, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D. Coroner

11/14/30 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Nov 12 1930

20 UNDERTAKER C. L. Bloom & Son

ADDRESS 108 W. Monument

M. & T.—100 B—50L

2266

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62266

CERTIFICATE OF DEATH

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) 522 Wilmer ST. 14-20 (WARD)

2-FULL NAME Ida Neal

(a) RESIDENCE NO. 522 Wilmer ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col'd	Widow

If married, widowed or divorced HUSBAND of (or) WIFE of Stephen Neal

ATE OF BIRTH (month, day, and year) 1884

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hazie Thomas

(Address) 1005 N. Eutaw

Filed ..... WILSON G. JONES, M. D. Registrar

Rec'd .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows*:

Interstitial Nephritis.

..... (duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. F. Hoskins Coroner, M. D.

(Address) 1400 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Nov 13 1930

20 UNDERTAKER Wm. M. Chase & Son — ADDRESS 1400 Madison

1-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62267 CERTIFICATE OF DEATH 129 E 62267

REGISTERED NO.

PLACE OF DEATH 504 N. Cross St

OF BALTIMORE: (a) (Real) ST. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME George Carter

RESIDENCE NO. 504 N. Cross ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

of residence in city nr town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Carter

E OF BIRTH (month, day, and year): 1886 Nov 17

Years	Months	Days	If LESS than 1 day, hrs. or min.
44	11	22	

UPATION OF DECEASED

Trade, profession or ticular kind of work: Porter

General nature of industry, siness, or establishment in ich employed (or employer):

Name of employer: Washington D.C.

THPLACE (city or town) tate or country)

NAME OF FATHER: Benyman Neal

BIRTHPLACE OF FATHER (city or town) (State or country): Washington, D.C.

MAIDEN NAME OF MOTHER: Lucie Carter

BIRTHPLACE OF MOTHER (city or town) (State or country):

Informant: Ella Carter

(Address) 504 N. Cross St.

Filed 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8. 1930

17 I HEREBY CERTIFY, that I attended deceased from Sept 24 1930 to Nov 8 1930

that I last saw him alive on Nov. 8 1930

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary): Uremia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H. H. Hopkins M. D.

. 19 (Address) 501 N. Glenburn St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C.

DATE OF BURIAL: 11/12/ 1930

20 UNDERTAKER: Mrs Chas H. Bailey

ADDRESS: 1122 Jefferson St

1-30—M. & T.—250 Bks.

62268

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 62268

CERTIFICATE OF DEATH.

REGISTERED NO.

PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 6-8 WARD)

FULL NAME Mary Ellis

) RESIDENCE NO. 1303 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write~~ the word)
male	Colored	Bely

married, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year)

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7		

CUPATION OF DECEASED

a) Trade, profession or particular kind of work None.

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) (State or country) Md

0 NAME OF FATHER Frank Ellis

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md

2 MAIDEN NAME OF MOTHER Elizabeth Carter

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant, Rivers (Address) JOHNS HOPKINS HOSPITAL

Filed 12 1930 19 H. Mortimer Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 10/30.

17 I HEREBY CERTIFY, That I attended deceased from October 31, 1930 to November 10, 1930,

that I last saw he alive on November 10, 1930,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Xray. Autopsy.

(Signed) Dan Kuttner, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 12/3 1930

UNDERTAKER

ADDRESS Mrs Shaw 21 Baltzer & Jefferson

1-30—M. & T.—250 Bks

E 62269 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62269

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) Mercy Hospital ST. 10-13 (WARD)

FULL NAME Eugene Butler

RESIDENCE NO. 1415 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

(If married, widowed, or divorced (HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 10, 1892

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boat Wash off

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) New Jersey

NAME OF FATHER Elias Butler

BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

MAIDEN NAME OF MOTHER Hester Simms

BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

Informant (Address) Hospital Records

Filed 12 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930, to Nov 10, 1930, that I last saw him alive on Nov 10, 1930, and that death occurred, on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tonsilitis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Routine + Autopsy

(Signed) J. H. Goodman, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery Cem.

DATE OF BURIAL 11-12 1930

ADDRESS

20 UNDERTAKER Byron Wright 1218 Mt Calvery St

1-30—M. & T.—250 Bks.

09 6

62270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-E 62270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 8-17 WARD)

FULL NAME Baby Dibbern

) RESIDENCE NO. 2133 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
n/c White	

married, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year) Sept 15-30

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	28 45	

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) (State or country) Md

0 NAME OF FATHER Bernard Dibbern

1 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

2 MAIDEN NAME OF MOTHER Elizabeth Lehman

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed DEC 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-11-30

17 I HEREBY CERTIFY, That I attended deceased from Sept-28, 1930, to Nov. 11, 1930.

that I last saw him alive on Nov. 11, 1930, at 1.35 P.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pharyngitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Jameson, M. D.

11/11, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 13 1930

UNDERTAKER Wm C. Miller & Son — ADDRESS 2314 Eastern Ave

0-30—A. & Co.—250 Bks

E 62271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 62271

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 216 S. Dallas St.) 3-4 (WARD)

FULL NAME Eliza Harris

(a) RESIDENCE NO. 216 S. Dallas ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nelson Harris

6 DATE OF BIRTH (month, day, and year) 9/1/1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Jacob Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Nelson Harris

(Address) 216 S. Dallas

Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11-30

17 I HEREBY CERTIFY. That I attended deceased from 3-16-, 1930, to 11-11-, 1930 that I last saw h alive on 11-10-, 1930 and that death occurred, on the date stated above, at 12.05 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

11-11-1930 (Address) 611 N. Carolin

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL 11/13/30.

20 UNDERTAKER George J. Pfeltz Inc

ADDRESS 1735 Hanover

1-30—M. & T.—250 Bks.

Warne

2272 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62272

CERTIFICATE OF DEATH. x 1291

REGISTERED NO.

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. St. Joseph's Hospital ST., 491 WARD)

FULL NAME Elizabeth Warne,

RESIDENCE (No. 821 Harpers St. WARD Parkwood rd.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female, white,	married.

If married, widowed, or divorced
(HUSBAND of or) WIFE Wm. Warne

DATE OF BIRTH (month, day, and year) 3-1-1895

Years	Months	Days	If LESS than 1 day hrs. or min.
35	8	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto md

NAME OF FATHER Luther Duvall

BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

MAIDEN NAME OF MOTHER Blanton Duvall

BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

Informant Wm. Warne
(Address) Old Harford Rd

Filed 12-1-30 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10-30

17 I HEREBY CERTIFY, That I attended deceased from 10-30, 1930 to 11-10, 1930, that I last saw h[illegible] alive on 11-10-30, 19..., and that death occurred, on the date stated above, at 12.04 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Uraemic Pericarditis - Endocarditis (Duration) at least yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical signs, & laboratory

(Signed) Lawrence [illegible] Love, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 11/12/30, 19

20 UNDERTAKER George J. Roth Inc ADDRESS 1736 Hollins

10-10-29—A Co.—100 Bks.

E 62273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 62273

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH: (No.) So. Balto Gen. Hosp St., 31 (Ward)

of Baltimore:

2-FULL NAME: Harry J Mullen

(a) RESIDENCE NO. 116 W. Fort Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) May - 1905

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	6		

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Elec. Truck Opr.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

BIRTHPLACE (city or town)
(State or country) Balto Md

10 NAME OF FATHER Pat. J. Mullen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Dorsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Mrs. Lilie Clemens
(Address) 116 W Fort Ave

15 Filed ..... 19.. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto in which he was riding overturned crushing him - I

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hanover & Fonvell

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Evans, M. D.

Nov 14 1930 (Address) 29 Sgnet Elden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemtry — DATE OF BURIAL Nov 13 1930

20 UNDERTAKER F. A. Krauss Son — ADDRESS 703 Hamm

1-30—M. & T.—250 Bks

Dr Billups 2224 W. North Ave 2/3344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62271 129 E 62274

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 1815 N. Bentalou ST. 15-6 (WARD)

FULL NAME Minnie Lenkuhl

RESIDENCE NO. 1815 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
(HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9th 1860

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	1	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Balto Md

9 NAME OF FATHER Chas Lenkuhl

10 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

11 MAIDEN NAME OF MOTHER Sophia Wagner

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs W. S. Sager

(Address) 1815 Bentalou st

Filed Dec 1 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

14 DATE OF DEATH (month, day, and year) Nov 10th 1930

15

I HEREBY CERTIFY, That I attended deceased from Oct 5 1930, to Nov 10 1930,

that I last saw her alive on Nov 10 1930,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. 6 mos 10 da.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. 6 mos. 10 da.

16 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. + Urinary Exam

(Signed) G W Billups, M. D.

, 19 (Address) 2224 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 11/13/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

M. & T.—100 B—50L

E 62275

62275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

24-32

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) 612 Hyson St. ST. (WARD)

2-FULL NAME John F. Silver.

(a) RESIDENCE NO 612 Hyson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of ~~XXXXXXXXXX~~ Annie Silver.

6 DATE OF BIRTH (month, day, and year) April 6, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	7	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Franklin Silver.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Louise Lowman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant John H. Silver. (son)

(Address) 612 Hyson St.

15 FILED 12 1930 C. HAMPSON JONES, M. D. Registrar

121930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 9, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Reinhardt Coroner, M. D.

11/10/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 11/12/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

-29-28—L. F. S.—500 Bks.

E 62276 HEALTH DEPARTMENT—CITY OF BALTIMORE 1296 E 62276

CERTIFICATE OF DEATH

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. 3419 Elliott ST. 26-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Madeline Hammen

RESIDENCE NO. 3419 Elliott ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

arried, widowed, or divorced HUSBAND of or) WIFE of the late George Hammen

E OF BIRTH (month, day, and year) Mch 4 1870

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	8	6	

UPATION OF DECEASED

Trade, profession or ticular kind of work Retired

General nature of industry, iness, or establishment in ch employed (or employer)

Name of employer

THPLACE (city or town) ate or country) Dalto Md.

NAME OF FATHER John Hartman

BIRTHPLACE OF FATHER (city or town) Germany (State or country)

MAIDEN NAME OF MOTHER Mary Herpich

BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

Informant Agnes Kelch (Daughter)

(Address) 3419 Elliott St

Filed 2 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10th 30

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to Nov 10, 1930;

that I last saw h alive on Nov. 10, 1930

and that death occurred, on the date stated above, at 1249 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypertension - arteriosclerosis

Chr. Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Toubey M. D.

, 19 (Address) 804 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery.

DATE OF BURIAL: Nov. 13th 1930

20 UNDERTAKER: Lilly & Zeiler Inc.

ADDRESS: 403 S. Wolfe St

-29-28--L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62277 90 ✓ E 62277

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. 2022 Gough ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Harry D. Lusby

RESIDENCE NO. 2022 Gough ST., 7 WARD
(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	Married

arried, widowed, or divorced HUSBAND of or) WIFE of Elizabeth J. Lusby

E OF BIRTH (month, day, and year) May 5 1871

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	6	7	

EPATION OF DECEASED

Trade, profession or ticular kind of work Grinder at Sp

General nature of industry, iness, or establishment in ich employed (or employer) Liverwgt Coffee

Name of employer Warehouse H

THPLACE (city or town) ate or country) Balto. Md.

NAME OF FATHER ?

BIRTHPLACE OF FATHER (city or town) U. S.
(State or country)

MAIDEN NAME OF MOTHER ?

BIRTHPLACE OF MOTHER (city or town) U. S.
(State or country)

Informant Elizabeth J. Lusby

(Address) 2022 Gough St.

Filed 12 1930 E. HARTON JONES, H. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1930, to Nov. 10, 1930, that I last saw h[illegible] alive on Nov. 10, 1930 and that death occurred, on the date stated above, at 5 15/a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2ds.

CONTRIBUTORY (Secondary) Cardio-Renal Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [illegible], M. D.

11-11-30 .19 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Nov. 12th 1930

20 UNDERTAKER Lieby & Zeiler Inc.

ADDRESS 403 S. Wolfe St

1-30—M. & T.—250 Blks.

62278 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 62278

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) 1758 Llewelyn Ave (WARD) 816

FULL NAME Cleo Thompson

RESIDENCE NO. 1758 Llewelyn Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colo.	married

If married, widowed, or divorced
(HUSBAND of or) WIFE of Lepio Thompson

DATE OF BIRTH (month, day, and year) July 6 1904

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
26	6	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N.C.

10 NAME OF FATHER Joseph N. Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Sula Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

Informant Elmer J. Hodges

(Address) 1758 W. Lanvale St.

C. HAMPSON JONES, M. D.

Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9/30

17 I HEREBY CERTIFY, That I attended deceased from 10/27/30, 19..., to 11/9/30, 19...,

that I last saw her alive on 11/8/30, 19...,

and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Acute (duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Chronic Recurrent Bronchitis (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] Barker M. D.

(Address) 1908 S Shark St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cemetery

DATE OF BURIAL Nov 12, 1930

20 UNDERTAKER Mrs. Katie P. Williams

ADDRESS 322 N Schroeder St

12-23—MAT—500 Blks.

62279 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62279

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

(a) CITY OF BALTIMORE: (No.) 1137 N. Calhoun ST. 16-23 (WARD)

2. FULL NAME Louisa M. Lynn

(a) RESIDENCE NO. 1137 N. Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
(b) Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widow

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Josiah Lynn

7 DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	58	✓	✓	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer): Housework
(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Estelle Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant (Address): Clarence C. Lynn 1137 N. Calhoun St.

C. HAMPSON JONES, M. D. Registrar

2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1930, to Nov 8, 1930.
that I last saw her alive on Nov 8, 1930,
and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis ?

(duration) ? yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) ? yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W. S. Taylor M. D.
11/11, 1930 (Address) 1522 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Nov 12, 1930

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 322 W. Lafayette Ave

12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62280

62280

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 3716 Roland Ave. WARD) 13-52

FULL NAME James M. Davis

RESIDENCE NO. 3716 Roland Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	Single

Male

married, widowed, or divorced

HUSBAND of

(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 1865

AGE Years	Months	Days	If LESS than 1 day, hrs or min.
65		8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER James R Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Gosson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Emma Davis

(Address) 3716 Roland Ave

Filed JONES, 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Nov 11, 1930,

that I last saw h alive on Nov 11th, 1930,

and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Arteric Sclerosis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) [illegible], M. D.

Nov 11, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

20 UNDERTAKER W E Gossom

DATE OF BURIAL Nov 14 1930

ADDRESS 844 W Baltimore St

LAON

1-30—M. & T.—250 Bks.

62281 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62281

CERTIFICATE OF DEATH.

REGISTERED NO. 90.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH OF BALTIMORE: (No.) South Baltimore Gen'l Hosp. ST., (WARD)

FULL NAME John H. Dreesleen

RESIDENCE NO. 1828 Wilkins ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	married

Married, widowed, or divorced (HUSBAND of (or) WIFE of) Margaret Dreesleen

DATE OF BIRTH (month, day, and year) June 23 1881

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	5	16	17

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

NAME OF FATHER Unknown

BIRTHPLACE OF FATHER (city or town) (State or country) Germany

MAIDEN NAME OF MOTHER Caroline Bucher

BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Margaret E Dreesleen

(Address) 1828 Wilkins ave

Filed 1930 Registered by W. [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1930, to Nov 10, 1930, that I last saw him alive on Nov 10, 1930, and that death occurred, on the date stated above, at 2 07 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1828 Wilkins ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J. Sullivan M. D.

, 19 (Address) So. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 11/12 1930

20 UNDERTAKER Geo C Farley

ADDRESS 1800 N Fayette

21930

1-30—M. & T.—250 Bks.

62282

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62282

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 1325 Glyndon Ave ST. WARD)

FULL NAME Virian Mary Liupsetris

) RESIDENCE NO. 1325 Glyndon Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

married, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year) June 1.1930

E ____ Years	5 Months	10 Days	If LESS than 1 day, ____ hrs. or ____ min.

CUPATION OF DECEASED

a) Trade, profession or particular kind of work No.

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) Baltimore Md.
State or country)

0 NAME OF FATHER Joseph Liupsetris

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

2 MAIDEN NAME OF MOTHER Pauline Paranskis

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithvania

Informant Joseph Liupsetris
(Address) 1325 Glyndon Ave

Filed NOV 12 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov-8, 1930, to Nov 11, 1930.

that I last saw h[illegible] alive on Nov. 11- 1930.

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronch Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Ethanetion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Thos. C. Blake, M. D.

, 19 (Address) 719 Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A.C. DATE OF BURIAL Nov. 13. 1930

20 UNDERTAKER John Grebliauckas ADDRESS 423 E Pleasant St.

1-30—M. & T.—250 Bks.

E 62283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 62283

REGISTERED NO. 15-62

PLACE OF DEATH
OF BALTIMORE: (No.) St Joseph's Hospital ST., WARD
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME John R. Lambie

RESIDENCE NO. 3701 Edgewood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 69 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	Married

If married, widowed, or divorced
(or) HUSBAND of
(or) WIFE of Emma A. Rogge

DATE OF BIRTH (month, day, and year) 1861

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	---	--	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

Informant Miss Edith Lambie
(Address) 3701 Edgewood Road

Filed ..... 19 ..... HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1930, to Nov 11, 1930, that I last saw h-- alive on Nov. 11, 1930, and that death occurred, on the date stated above, at 11 40 a.m.

The CAUSE OF DEATH* was as follows:
Cardiac failure
Myocarditis
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerotic cardiovascular disease (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Wm Blanchard M. D.
, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/13 1930

20 UNDERTAKER Henry U. Mears and Son

ADDRESS 805 N. Calvert

21 1930

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62284

CERTIFICATE OF DEATH

24002 E 62284

PLACE OF DEATH

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. 3300 Auchentoroly Terrace WARD)

FULL NAME Lewin H. Burkhardt

RESIDENCE NO. 3300 Auchentoroly Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	married

married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Herman

E OF BIRTH (month, day, and year) July 22, 1869

Years	Months	Days	If LESS than 1 day, hrs or min.
61	3	19	

UPATION OF DECEASED

Trade, profession or particular kind of work Chief, 032

General nature of industry, business, or establishment in which employed (or employer) Fire Department of

Name of employer Baltimore City

BIRTHPLACE (city or town) Baltimore, Md.

NAME OF FATHER Jacob Burkhardt

BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

MAIDEN NAME OF MOTHER Phoebe Jacobs

BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

Informant Mrs. Lewin H. Burkhardt

(Address) 3300 Auchentoroly Terr.

C. HAMPSON JONES, M. D.

2 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930, to Nov 11th, 1930, that I last saw him alive on Nov 11th, 1930 and that death occurred, on the date stated above, at 7.30A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur J. Gebhart, M. D.

, 19 (Address) 211 Garat Tower

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Nov. 13, 1930

20 UNDERTAKER: John O. Mitchell & Sons — ADDRESS: 1900 Eutaw Pl.

John O. Mitchell

8-16-29—L. F. S.—100 Bks.

62285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62285

REGISTERED NO. 27-53

PLACE OF DEATH

Y OF BALTIMORE: (No. 203 Club Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Grace Edmunds Deming

) RESIDENCE NO. 203 Club Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	married

narried, widowed, or divorced
HUSBAND of (or) WIFE of John B. Deming

TE OF BIRTH (month, day, and year) Sept.3,1880

Years	Months	Days	If LESS than 1 day, hrs. or min.
50	2	8	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Housewife

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Baltimore, Md.
State or country)

) NAME OF FATHER James R. Edmunds

) BIRTHPLACE OF FATHER (city or town) Richmond, Va.
(State or country)

2 MAIDEN NAME OF MOTHER Anna Keyser

3 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

Informant John B. Deming

(Address) 203 Club Road

2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1930

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1930, to Nov 11, 1930, that I last saw h alive on Nov 10, 1930 and that death occurred, on the date stated above, at 7.20 a m.

The CAUSE OF DEATH* was as follows:

Repeated cerebral embol from heart in Chronic fibrillation (auricular) last series of emboli

(duration) yrs. mos. 1d ds.

CONTRIBUTORY (Secondary) Chronic lesion of aortic valves since childhood (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

11.12, 1930 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov. 13, 1930
20. UNDERTAKER John O. Mitchell & Sons, 19	ADDRESS 0 Eutaw Plac

-29-28—L. F. S.—500 Blks.

62286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

104-002 E 62286

PLACE OF DEATH

OF BALTIMORE: (No. 5602 Marguerite Ave. WARD) 27-43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Gilbert L Taylor

RESIDENCE NO. 5602 Marguerite ave

(Usual place of abode)

WARD

(If non-resident give city or town and State)

of residence in city or town where death occurred yrs. 2 mos 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

E OF BIRTH (month, day, and year) Aug 18th 1930

Years	Months	Days	If LESS than 1 day, hrs. or min.
—	2	24	

UPATION OF DECEASED

Trade, profession or ticular kind of work none

General nature of industry, iness, or establishment in ich employed (or employer)

Name of employer

THPLACE (city or town) Baltimore
tate or country) Md

NAME OF FATHER Weldon H Taylor

BIRTHPLACE OF FATHER (city or town)
(State or country) Somerset Co Md

MAIDEN NAME OF MOTHER Hazel Greenwood

BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

Informant Weldon H Taylor
(Address) 5602 Marguerite ave

Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 1930, to Nov 11 1930, that I last saw h alive on Nov 9 1930 and that death occurred, on the date stated above, at 130 P m.

The CAUSE OF DEATH* was as follows:

Tonsilitis & Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Glottis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claud Fenwick, M. D.

Nov 12 1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov 13 1930

UNDERTAKER George S Lilling & Sons

ADDRESS 1126 E Monument St

1-30—M. & T.—250 Bks.

62287 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 62287

CERTIFICATE OF DEATH.

147

REGISTERED NO.

PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

JOHNS HOPKINS HOSPITAL

OF BALTIMORE: (NO. 6-10 ST. WARD)

FULL NAME Ella Manly

RESIDENCE NO. 113 N. Bradford ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

married, widowed, or divorced (HUSBAND of or) WIFE of George

TE OF BIRTH (month, day, and year) Aug 17- 1895

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	2	24	

CUPATION OF DECEASED

a) Trade, profession or particular kind of work N.W.

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) (State or country) Md

0 NAME OF FATHER Robt Abel

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md

2 MAIDEN NAME OF MOTHER Sarah Allen

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records

(Address)

21950 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-10-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930 to Nov 10, 1930.

that I last saw h[illegible] alive on Nov 10, 1930.

and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Phlebitis following delivery (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood culture

(Signed) Charles H. McLane, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakwood

DATE OF BURIAL 11/13 1930

20 UNDERTAKER Philip Hennig

ADDRESS 2016 Orleans St

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62288

2288

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 2116 W. North Ave ST. 15-18 WARD)

FULL NAME Willie G Smith

) RESIDENCE NO. 2116 W. North Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 6/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
nale	White	Married

narried, widowed, or divorced

(~~HUSBAND of~~ WIFE of William H. Smith

TE OF BIRTH (month, day, and year) May 16 1863

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	23 24	

CUPATION OF DECEASED

a) Trade, profession or particular kind of work None

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) (State or country) Maryland

0 NAME OF FATHER Nathan Mc Alister

1 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

2 MAIDEN NAME OF MOTHER Julia Walker

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Wm. H. Smith

(Address) 2116 W. North Ave

Filed 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 19 30, to Nov. 10, 19 30, that I last saw h~~er~~ alive on Nov. 10, 19 30, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Stethoscope

(Signed) C. H. Carden, M. D.

, 19 (Address) 3707 Calloway Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Nov 13 1930

UNDERTAKER Sasseen Eyler & Co

ADDRESS W North

—9-30—A. & Co.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2289

CERTIFICATE OF DEATH.

129 E 62289

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No 814 S. Luzerne Ave,. St. 1-2 WARD)

1 FULL NAME George Butzner

a) RESIDENCE NO. 814 S. Luzerne Ave,. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amelia Butzner

ATE OF BIRTH (month, day, and year) 6 - 9 - 1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74		6 5	1 4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Conrad Butzner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md,.

12 MAIDEN NAME OF MOTHER Margaret ---?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Amelia Butzner 814 S. Luzerne Ave,.

1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10-30

17 I HEREBY CERTIFY, That I attended deceased from October 11, 1930, to Nov. 10, 1930

that I last saw h m alive on Nov 10, 1930

and that death occurred, on the date stated above, at 3.05 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(duration) yrs. ~~months~~ months.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard Jones M. D.

11/12, 1930 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery

DATE OF BURIAL 11-14-30

20 UNDERTAKER W. E. Humphreys

ADDRESS 2416 E. Lafayette Ave

-10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

166 E 62290

62290

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Union Memorial Hospital St. 18-7 Ward)

of Baltimore: (No.

2-FULL NAME Grace Powers.

(a) RESIDENCE NO. 734 E. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) April 14 1894

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	36	6	21	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town)
(State or country) Maryland

10 NAME OF FATHER Peter Powers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Kelley
(Address) 522 E 25th St.

15 Filed 2 1930 19 HARRISON JONES, M. D. Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Lysol Poisoning
Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Jan Mossman, M. D.
11/10 1930 (Address) 3672 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Dem Bltsmore Health

ADDRESS

NOV 1 1930

10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62291

CERTIFICATE OF DEATH

90 E 62291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

y of Baltimore: (No. 272 N. Exeter St. St., 5-8 Ward)

2-FULL NAME William France. (C)

(a) RESIDENCE NO. 272 N. Exeter St., Ward

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 60 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
ale	Colored	Do not know.

If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

DATE OF BIRTH (month, day, and year) Do not know.

AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	60	----	----	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md
(State or country)

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report, C.D.
(Address)

15 Filed ..., 19... HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 1, 1930 152

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) C. H. M. Reinhardt, M. D.

11/7. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL ... 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
THE MORGUE
NOV 1 1930

1-30—M. & T.—250 Bks.

62292 HEALTH DEPARTMENT—CITY OF BALTIMORE V 62292

CERTIFICATE OF DEATH. X 16-00[illegible]

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

FULL NAME Denny Barr

) RESIDENCE NO. Edgemere Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	

married, widowed, or divorced
HUSBAND of
or) WIFE of

TE OF BIRTH (month, day, and year)

E	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5		

CUPATION OF DECEASED)

) Trade, profession or particular kind of work Child

) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) Edgemere, Md.
State or country)

0 NAME OF FATHER John H. Barr

1 BIRTHPLACE OF FATHER (city or town)
(State or country)

2 MAIDEN NAME OF MOTHER

3 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant Records JOHNS HOPKINS HOSPITAL
(Address)

Filed ..... 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1930, to Nov 9, 1930, that I last saw h~~im~~ alive on Nov 9, 1930, and that death occurred, on the date stated above, at 5 10 P m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Edgemere, Md

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Kuttner, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: NOV 12 1930

UNDERTAKER: Commissioner Health

ADDRESS

Rec. Wm. E. WOODALL

—9-30—A. & Co.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

2293 62293

CERTIFICATE OF DEATH.

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH Johns Hopkins Hospital

(a) CITY OF BALTIMORE: (No. 17-51 ST. (WARD)

2. FULL NAME Baby Purcell

(a) RESIDENCE No. 2112 Oak St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 14/1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work 0-0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Julius Purcell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Bertha Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant (Address) Johns Hopkins Hosp.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-14-1930, to 7-17-1930.

that I last saw h in alive on 7-17-1930.

and that death occurred, on the date stated above, at 6 00 a.m.

The CAUSE OF DEATH* was as follows:

Intracranial haemorrhage.
Congenital heart disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Spinal Lumbar Cut Specimen

(Signed) A H Harrison M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health — ADDRESS

JOHNS HOPKINS HOSPITAL

NOV 12 1930

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-00 E 62294

E 62294

REGISTERED NO.

—PLACE OF DEATH

Y OF BALTIMORE: (No. 430 N Fremont Ave (ST.) 18-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Miscarriage

) RESIDENCE NO. 430 N Fremont Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: male Colored

5 Single, Married, Widowed, or Divorced, (write the word)

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) Nov 11 1930

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

UPATION OF DECEASED

Trade, profession or rticular kind of work: Miscarriage

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Balt. MD.
tate or country)

NAME OF FATHER Jessie Alfonzo Small

BIRTHPLACE OF FATHER (city or town) N.C.
(State or country)

2 MAIDEN NAME OF MOTHER Rebecca Jane Walker

3 BIRTHPLACE OF MOTHER (city or town) N.C.
(State or country)

Informant Mother & Sally
(Address) 430 N Fremont Ave

Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1930, to Nov 11, 1930, that I last saw her alive on Nov 11, 1930, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Miscarriage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George W. McDonald, M. D.

, 19 (Address) 900 N Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: D 19

UNDERTAKER: Commissioner Health.

ADDRESS NOV 12 1930

10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62295

CERTIFICATE OF DEATH

185 E 62295

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

(a) City of Baltimore: (No.) Balt City Hosp St. 90-72 Ward)

2-FULL NAME Thomas Ozman

(a) RESIDENCE NO. 223 Wilkens Ave St., Ward

(Usual place of abode) (If non-resident give city or (town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma Ozman

DATE OF BIRTH (month, day, and year) Jan 20 1891

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39	9	21	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Emmorium
(State or country) Md

10 NAME OF FATHER John H. Ozman

11 BIRTHPLACE OF FATHER (city or (own) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Ida V. Thomas

13 BIRTHPLACE OF MOTHER (city or (own)
(State or country) Maryland

14 Informant Mrs. Ida Ozman
(Address) 73 Bartlett Ave

15 Filed C. HAMPSON JONES, M. D. Registrar
2 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of Skull (ver)
Temporal & Parietal L.
Sid

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Severe Hemorrhage
in Brain (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) James M Hamilton, M. D.

11 12 1930 (Address) 701 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stevensville Md	Nov 13 1930
20 UNDERTAKER J. A. Wilbert Sons	ADDRESS Belair

1-30—M. & T.—250 Bks

62296 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62296

CERTIFICATE OF DEATH. 44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

a) OF BALTIMORE: (No. 311 S. Ann ST., 2-4 WARD)

b) FULL NAME Alton Brooks

c) RESIDENCE NO. 311 S. Ann ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

d) Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
(HUSBAND of
or) WIFE of

7 DATE OF BIRTH (month, day, and year) Dec 10th/81

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	2	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer at Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Crown Cork. Co.

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER James Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Delethia Brumbley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant James Brooks Bro.

(Address) 311 S. Ann St.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12th/30

17 I HEREBY CERTIFY, That I attended deceased from Oct-22- , 1930, to Nov-12- , 1930, that I last saw h[illegible] alive on Nov-12- , 1930, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

about-6 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-rays

(Signed) Herman Siedel, M. D.

1930 (Address) 2404 Entaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL Nov. 14th 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St.

2 1930

J. HAMPSON JONES, M. D.

M. & T.—100 B—50L

62297

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62297

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1916 W La Fayette St. 16-22 WARD)

2-FULL NAME Alexander Dorsey

(a) RESIDENCE NO. 1916 W La Fayette St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single.

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. Md.
(State or country)

10 NAME OF FATHER Dr. Julian Dorsey

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER McKenney

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mamie Dorsey

(Address) 1916 W La Fayette St.

NOV 2 1930 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows: Coronary Sclerosis, Hypertrophy & Dilatation of heart and General Arterio Sclerosis (duration) 1 or more

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes (Dr. Maldeis)

What test confirmed diagnosis?

(Signed) M. D. Coroner

Nov 19 30 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Co. Prince Frederick Md. DATE OF BURIAL Nov 13 1930

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

1-30—M. & T.—250 Bks

Dr Compton 301 Conn St ✓

62298 HEALTH DEPARTMENT—CITY OF BALTIMORE 62298

CERTIFICATE OF DEATH. 101-25-75

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) 3906 Hanover ST. W. WARD

FULL NAME Lee Franklin Floyd

RESIDENCE NO. 3906 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mulatto	Single

(If married, widowed, or divorced) HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 1, 1930

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

NAME OF FATHER James A Floyd

BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

MAIDEN NAME OF MOTHER Estelle Darby

BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant James A Floyd

(Address) 3906 Hanover St

Filed 12 1930 J. HAMPSON JONES, Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Nov. 12, 1930,

that I last saw he alive on Nov 12, 1930,

and that death occurred, on the date stated above, at 12. N. m.

The CAUSE OF DEATH* was as follows:

Rickettsia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G. E. Compton M. D.

11/12 1930 (Address) 301 East Conn St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 11/15 1930

20 UNDERTAKER J. M. Cook

ADDRESS 1217 Pine St

12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62299

62299

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

of BALTIMORE: (No.) 3500 Clifton Av. St. 15-61 Ward)

2-FULL NAME James Edgar Wylie

(a) RESIDENCE NO. 3500 Clifton Av. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 65 yrs. 10 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Mathilde O. Wylie

6 DATE OF BIRTH (month, day, and year): December 28 1864

7 AGE: Years 65 Months 10 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work: Credit Mgr

(b) General nature of industry, business, or establishment in which employed (or employer): for Balto Basin

(c) Name of employer: of Credit Men Harrisburg

9 BIRTHPLACE (city or town): Harrisburg (State or country): Penna

10 NAME OF FATHER: Geo. M. Wylie

11 BIRTHPLACE OF FATHER (city or town): Harrisburg (State or country): Penna

12 MAIDEN NAME OF MOTHER: Ella Finley

13 BIRTHPLACE OF MOTHER (city or town): Harrisburg (State or country): Penna

14 Informant: Wm. M. Caspari Wylie (son)

(Address) 309 Walbrook Ave.

1930 C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): NOV 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) .....yrs. 6 mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) H. O. Funk M. D. (Coroner)

Nov 12 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial Nov 13 1930

20 UNDERTAKER: Stewart & Hooper Company ADDRESS 108 W Mond

1-30—M. & T.—250 Bks

62300

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62300 E 62300

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 3100 Louise Ave ST. 27-43 WARD)

FULL NAME Mary A. Munro

) RESIDENCE NO. 3100 Louise Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ual 4	White	Married

married, ~~widowed, or divorced~~ (or) WIFE of Gilbert Munro

TE OF BIRTH (month, day, and year) Feb 22nd 1862

E Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	8	19	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Wm H. Lambith

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eliza Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Gilbert Munro

(Address) 3100 Louise Ave

HARRISON JONES, M. D.

2 1930 ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Nov 11, 1930

that I last saw h[illegible] alive on Nov 11, 1930

and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Myocarditis

(duration) several years yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis many years.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

11/12 1930 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 11/14/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

1-30—M. & T.—250 Bks

Dr Lloyd. 2252 Eutaw Place

62301 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62301

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 1214 West North Ave. ST., 13-59 WARD)

FULL NAME Mary E. Lewis

) RESIDENCE NO. 1214 West North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Widow

married, widowed, or divorced
HUSBAND of
or) WIFE of John T.K. Lewis

TE OF BIRTH (month, day, and year) Oct. 5, 1842

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	1	7	

CUPATION OF DECEASED

a) Trade, profession or particular kind of work House work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer At. Home

IRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER William B. Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Kirchner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Gertrude Kauffman

(Address) 1214 West North Ave.

2 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1930, to Nov 12, 1930, that I last saw her alive on Nov 11, 1930 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E O Lloyd, M. D.

, 19 (Address) 2252 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 11/15 19

20 UNDERTAKER W. Holbrook Cook

ADDRESS 1217 St. Paul

—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62302

90 E 62302

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 434 Barley St. 12-19 (Ward)

2-FULL NAME Martha A. H. Clever

(a) RESIDENCE NO. 434 Barley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	C	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Mar 15- 877

AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	Abt 53		26	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Ot Home 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Md
(State or country)

10 NAME OF FATHER E E Boone

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant A Cole
(Address) 441-E-23rd St

15 [illegible] H. HANSON JONES, M. D. Registrar

19 31 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular
Nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Monroe, M. D.

12-12-1930 (Address) 5632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-14 1930

20 UNDERTAKER Jas. M. Skinner

ADDRESS 1625 E. Madison St

1-30—M. & T.—250 Bks

62303 HEALTH DEPARTMENT—CITY OF BALTIMORE X 47 ✓ E 62303

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) 1222 N. Caroline St. (WARD) 10-13

FULL NAME Mary K. Elliott

RESIDENCE NO. 1222 N. Caroline St. WARD

(Usual place of abode) (If non-resident give city or town and State) New Jersey

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Married

If married, widowed, or divorced (HUSBAND) of (or) WIFE of Wm. H. Elliott

DATE OF BIRTH (month, day, and year) Jan. 24 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	18	

OCCUPATION OF DECEASED None 07

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pittsburgh Pa.

10 NAME OF FATHER John R. Lyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rosanna Keplinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Mrs. Ella F. Brown

(Address) 1222 N. Caroline St

Filed 1-3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1930

17 I HEREBY CERTIFY, That I attended deceased from June 27-, 1930, to Nov. 11-, 1930, that I last saw her alive on Nov. 10-, 1930, and that death occurred, on the date stated above, at 6.15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left breast

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

11/12/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL Nov. 13 30

UNDERTAKER Wm. Tickner Sons

ADDRESS North Ave

10-10-29—A Co.—100 Bks.

62304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-012 E 62304

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH (a) Thos. Hopkins Hosp (St.) 5-4 (Ward)
(b) of Baltimore: (No.) .....

2-FULL NAME Antonia Raczorowska

(a) RESIDENCE NO. 501 Nelson St St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

If married, widowed, or divorced
HUSBAND of (or) WIFE of .....

DATE OF BIRTH (month, day, and year) July 8, 1924

AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	6	4	2	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Raczorowska
11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)
12 MAIDEN NAME OF MOTHER Theresa Warzych
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Frank Raczorowski
(Address) .....

15 [illegible] HARRISON JONES, M. D.
Registrar

NOV 13 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows: Struck & knocked down by moving tractor while running across street

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract Skull
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Caroline & Monument
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. H. Young, M. D.
11-12 1930 (Address) 2131 Madeira Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary
DATE OF BURIAL 13 1930

20 UNDERTAKER J. W. Bozenski, 1930
ADDRESS Eastern Ave

1-30—M. & T.—250 Bks

E 62305 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 62305

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH Baltimore City Hospitals (T.B.)

OF BALTIMORE: (No. 43 & Fairfield ST. 12-51 WARD)

-FULL NAME Theresa Ciarpilla

) RESIDENCE NO. 406 Glen Edwards ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Married

married, widowed, or divorced (HUSBAND) of (or) WIFE of Anthony Ciarpilla

TE OF BIRTH (month, day, and year) May 15, 1887

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	5	27	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

IRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Salvadore Ramonda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Hospital Records

(Address)

C. HARRISON JONES,

Filed ..., 19 ... Registrar

13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1930, to Nov. 12, 1930, that I last saw her alive on Nov. 12, 1930, and that death occurred, on the date stated above, at 12.25 a.m.

The CAUSE OF DEATH* was as follows: Tuberculosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Harold Feiner, M. D.

11-12 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary DATE OF BURIAL Nov 14 1930

20 UNDERTAKER ADDRESS

Geo Marshall 353 Fall Road

M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62306 E 62306

REGISTERED NO. 713

1-PLACE OF DEATH

62306

CITY OF BALTIMORE: (No.) Hopkins Hospital ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene DuJardin.

(a) RESIDENCE NO 703 Oriole Ave ST., WARD Balto Co Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 22/30

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			20 21	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Joseph DuJardin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belgium

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Joseph DuJardin

(Address) 703 Oriole Ave

15 Filed 13 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Intestinal Indigestion

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.

19 Nov 12/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cats Lawn

DATE OF BURIAL Nov 14 1930

ADDRESS

UNDERTAKER Frank Couch & Son 1906 Eutaw

M. & T.—100 M—501

E 62307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 62307

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 800 N. Patterson Pk Ave ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Coufal

(a) RESIDENCE NO. 1700 Lansing Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Coufal

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Czecho-Slovakia

10 NAME OF FATHER Anton Hromadnik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czecho-Slovakia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czecho-Slovakia

14 Informant Frank Coufal

(Address) 1700 Lansing Ave

15 Filed NOV 13 1930 C. HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellites

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..... Coroner, M. D.

10/13/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov 14 1930

20 UNDERTAKER Frank Cvach Son

ADDRESS 1906 Eastern Ave

1-30—M. & T.—250 Bks.

62308

HEALTH DEPARTMENT—CITY OF BALTIMORE

62308 E

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (NO. Sinai Hospital ST. 3-5 WARD)

FULL NAME Fannie Bernstein

RESIDENCE NO. 4 R Eden St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
nal	White	Widowed

married, widowed, or divorced
HUSBAND of
or) WIFE of Jacob Bernstein

TE OF BIRTH (month, day, and year)

E Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
72			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) Russia
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Rhona —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

Informant Lewis
(Address) 1432 Gala Ave

Filed ..... 19 .....

C. HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1930, to Nov. 12, 1930, that I last saw h... alive on Nov. 11, 1930, and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Complicated Arteriosclerosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Milton B. Kerr M.D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehmus Work. Road

DATE OF BURIAL 11-13- 1930

UNDERTAKER Jack Lewis

ADDRESS Balto 25

M. & T.—100 B—50L

E 62309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1938 E 62309

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 14-20 (WARD)

2-FULL NAME Thos. Bailey.

(a) RESIDENCE NO Sharrow point. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Samuel Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rose Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Frank Bailey

(Address) Sharrow Point

15 Filed 13 1938 22 HARRISON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide Infection due to Stab wound of chest.

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Sharrow Point.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Required

(Signed) H. O. Buck, M. D. Coroner

19 (Address) Nov 10 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Denniston Va — DATE OF BURIAL 11-13 1930

20 UNDERTAKER Denniston — ADDRESS 976 Eutaw

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62310

CERTIFICATE OF DEATH

90 E 62310

REGISTERED NO.

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No.) 925 Fulton Ave ST. 16-24 (WARD)

FULL NAME Beulah E Anderson

RESIDENCE NO. 925 N Fulton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) July 24 1891

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39	3	18	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work None

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Wicomico Co
(State or country) Md

0 NAME OF FATHER Lon W Anderson

1 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

2 MAIDEN NAME OF MOTHER Estelle Crawford

3 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant Norman T Anderson

(Address) 925 N Fulton Ave

3 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1930. to Nov 12, 1930.

that I last saw her alive on Nov 12 1930

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (doration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X.R.

(Signed) J. Thomas Fulton, M. D.

Nov 12 1930 (Address) 1001 N. Fulton st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Nov 14 1930

20 UNDERTAKER Feltman & Fox — ADDRESS 1723 W Lafayette Ave

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62311

62311

CERTIFICATE OF DEATH

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH Mt. Sin. Hospital

OF BALTIMORE: (No. 15-68 ST., WARD)

FULL NAME Mr Walter ~~Harold~~ Lee Macatee

RESIDENCE NO. 2804 Walbrook Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M/e	white	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs Macatee

E OF BIRTH (month, day, and year) June 2, 1878

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	10	9	

UPATION OF DECEASED

Trade, profession or particular kind of work Salesman 066

General nature of industry, business, or establishment in which employed (or employer)

Name of employer

RTHPLACE (city or town, State or country) Harford Co. Md.

NAME OF FATHER Frank B. Macatee

BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

MAIDEN NAME OF MOTHER Mary L. Glenn

BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

Informant Hospital Records

(Address)

Registered 13 1930 G. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11-30

17 I HEREBY CERTIFY, That I attended deceased from 11-6-, 1930 to 11-11, 1930

that I last saw h~~im~~ alive on 11-11-, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

1. Chronic myocarditis
2. Chronic Nephritis.

(duration) 5 yrs. (?) mos. ds.

CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John N. Chenault, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Co. Harford Co. Md.

DATE OF BURIAL Nov. 14, 1930.

20 UNDERTAKER Martin Fahey & Sons

ADDRESS 1827 W. North Ave

1-30—M. & T.—250 Bks.

62312 HEALTH DEPARTMENT—CITY OF BALTIMORE VE 62312

44

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH
OF BALTIMORE: (No. 725 Mura ST., 10-14 WARD)
FULL NAME Hilmer M. Gelbach
RESIDENCE NO. 725 Mura ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 57 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

Married, widowed, or divorced (HUSBAND of or) WIFE of Amanda E. Gelbach

DATE OF BIRTH (month, day, and year) Apr. 3 1873

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	7	9	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

NAME OF FATHER John Gelbach

BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

MAIDEN NAME OF MOTHER Susan Hunt

BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

Informant Mrs Amanda E. Gelbach
(Address) 725 Mura St

NOV 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/12/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12 -, 1930, to Nov. 12 -, 1930, that I last saw him alive on " - , 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall bladder

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Sept. - 1930
Was there an autopsy? No
What test confirmed diagnosis? Exploratory operation
(Signed) Edwin H. Fraley, M. D.
11/13/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Nov. 14 1930
20 UNDERTAKER Henry Koch Sons Inc. — ADDRESS 1016 E Eager St

1-30 M. & T.—250 Bks.

62313 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62313

CERTIFICATE OF DEATH.

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) 2713 E. Monument ST., 710 WARD)

FULL NAME Joseph G. Kraus

RESIDENCE NO. 2713 E. Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
...lo	White	Married

married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret M. Kraus

DATE OF BIRTH (month, day, and year) Sept. 11 1884

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46	2	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker 014

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

NAME OF FATHER Joseph Kraus

BIRTHPLACE OF FATHER (city or town) (State or country) Germany

MAIDEN NAME OF MOTHER Margaret Kraus

BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Margaret M. Kraus

(Address) 2713 E. Monument St

Filed ..... 19 ..... THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1930, to Nov. 12, 1930, that I last saw h[im] alive on Nov. 12 1930, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) ..... yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Wm. D. Ickmit, M. D.

Nov 13 1930 (Address) 701 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Nov. 15 1930

20 UNDERTAKER Henry Koch & Son, Inc.

ADDRESS 1501 E. Eager St

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-081 E 62314

E 62314

CERTIFICATE OF DEATH

REGISTERED NO.

—PLACE OF DEATH

Y OF BALTIMORE: (No. 3804 Strathmore Ave. ST. 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME William C. Norris,

) RESIDENCE NO. 3804 Strathmore Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
le	White	Married

married, ~~widowed, or divorced~~
HUSBAND of (or) ~~WIFE of~~ Elizabeth A. Norris,

TE OF BIRTH (month, day, and year) Sept. 16. 1853

E	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	1	26	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Clerk

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) State or country) Carroll Co. Md.

0 NAME OF FATHER John P. Norris,

1 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

2 MAIDEN NAME OF MOTHER Sophia Knight,

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co. Md.

Informan Mrs. Elizabeth A. Norris

(Address) 3804 Strathmore Ave

C. HAMPSON JONES, Registrar

OV 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930, to Nov 11, 1930, that I last saw h[e] alive on Nov 11, 1930 and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [signature], M. D.

11-12, 1930 (Address) St Paul & Preston Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Druid Ridge Cem

UNDERTAKER Geo. H. Sitte

DATE OF BURIAL NOV 14 1930

ADDRESS 2700 EDMONDSON AVE

& T.—100 B—50L

E 62315

5

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

183

REGISTERED NO. 30-129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

OF BALTIMORE: (No. South Baltimore General Hospital ST., WARD)

FULL NAME George H.V.Fuller.

RESIDENCE NO 510 Franklintown Rd. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred 16 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
le	White	Single

arried, widowed, or divorced
USBAND of
or) WIFE of ----------

E OF BIRTH (month, day, and year) November 22,1913

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
16	11	20	

CUPATION OF DECEASED
) Trade, profession or rticular kind of work Laborer.
) General nature of industry, siness, or establishment in hich employed (or employer)
) Name of employer

THPLACE (city or town) tate or country) Baltimore, Md.

NAME OF FATHER Vinson Fuller.

BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

MAIDEN NAME OF MOTH Margaretta Rotan.

BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

nformant Vinson Fuller. (father)

(Address) 510 Franklintown Rd.

Filed 3 1930, 192 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) November 11, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Laceration and hemorrhage of the brain. Rifle shot wound in the left eye while out gunning. Accidental death.

(duration) ... yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pasadena, A. A. Co. Md November 11, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas. M. Reinhardt, M. D. Coroner

11/18/30 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL Nov. 14 1930

UNDERTAKER Geo. H. Little

ADDRESS 2705 Edmondson Ave

1-30—M. & T.—250 Bks.

E 62316

E 62316 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

PLACE OF DEATH

OF BALTIMORE: (No. #1323 Mt Royal ave ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Eva James Stockdale

RESIDENCE No. #1323 Mt Royal ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Normal White

5 Single, Married, Widowed, or Divorced, (write the word): widow

married, widowed, or divorced

(If HUSBAND of or) WIFE of George W Stockdale

DATE OF BIRTH (month, day, and year) Oct 3 1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	1	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work 37

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER John Frist

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER Annie James

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware

Informant (Address): Mrs Ida Rockydale 1323 Mt Royal ave

DEC 13 1930

Filed ....., 19 ..... Registrar

HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/30

17 I HEREBY CERTIFY, That I attended deceased from July, 1930, to Nov 12, 1930, that I last saw her alive on Nov 12, 1930, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(Duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H H Woody, M. D.

, 19 (Address) 145 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 15 1930
20 UNDERTAKER	ADDRESS
J. Elmo Andersohn	M d

& T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

2317

CERTIFICATE OF DEATH

167-001 E 62317

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

of BALTIMORE: (No. 765 W. Lexington ST. 18-No WARD)

FULL NAME Calvin Mertz

RESIDENCE NO 765 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
	White	Unknown

arried, widowed, or divorced
USBAND) of
or) WIFE of

TE OF BIRTH (month, day, and year) 1869

Years	Months	Days	If LESS than 1 day, hrs. or min.
61			

CUPATION OF DECEASED
) Trade, profession or rticular kind of work Laborer
) General nature of industry, siness, or establishment in hich employed (or employer)
) Name of employer

THPLACE (city or town) tate or country) Md

NAME OF FATHER — Mertz

BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

formant U.S. Veterans Bureau
(Address) Fort McHenry, Md

[illegible] 1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Poisoned by illuminating gas. (Probably Suicide)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zellers, M. D. Coroner

11/11, 19 30 (Address) 229 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National

DATE OF BURIAL 11/13/30

20 UNDERTAKER Harry R. Wittle, 1410

ADDRESS 16 Edmondson Ave

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 ✓

62318 — REGISTERED NO. E 62318

PLACE OF DEATH

Y OF BALTIMORE: (No. 3632 Park Heights Av ST., 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Charles George Weaver

) RESIDENCE NO. 3632 Park Heights Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred (3) yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M.

married, widowed, or divorced
HUSBAND of (or) WIFE of Alice V Weaver

TE OF BIRTH (month, day, and year) Aug 10 51

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	2	1	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Painter

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) State or country) ~~Ohio~~ Md.

0 NAME OF FATHER W. Weaver

1 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

2 MAIDEN NAME OF MOTHER Mc Known

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Alice V Weaver

(Address) 3632 Park Heights Ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 30

17 I HEREBY CERTIFY, That I attended deceased from 9/IV/30, 19..., to 11/11/30, 19..., that I last saw h im alive on 11/11/30, 19..., and that death occurred, on the date stated above, at 11 a p m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Lt Maxilla

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Meyer Miller, M. D.

, 19 (Address) 3649 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Garrison Md.

DATE OF BURIAL Nov 14 1930

20 UNDERTAKER W M Carter

ADDRESS 2238 N Gay St

1-30—M. & T.—250 Bks.

42375
E 62319

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62319

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

FULL NAME Rebecca Dixon

RESIDENCE NO. 417 Summerset ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	married

(If married, widowed, or divorced) (HUSBAND of or) WIFE of Alexander Dixon

DATE OF BIRTH (month, day, and year) April 19/69

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	6	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John Bottom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alberta Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records

(Address)

Filed 1931 '19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-9-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1930, to Nov 9, 1930, that I last saw h[illegible] alive on Nov 9, 1930, and that death occurred, on the date stated above, at 9.31 p. m.

The CAUSE OF DEATH* was as follows:

Coronary occlusion

1 minute (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial failure

Hypertension arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of -

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) C. C. Bedell, M. D.

11/10, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Nov. 13, 1930

20 UNDERTAKER Mrs R.G. Elliott — ADDRESS 1725 Arlington Ave

1-30—M. & T.—250 Bks

Darlington

62320 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 E 62320

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

(a) OF BALTIMORE: (No.) 413 Grindall (WARD) 24-33

(b) FULL NAME Louis F Becker

(c) RESIDENCE NO. 413 Grindall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

(d) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
(a) HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) Feb 10th 1927

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Frank L Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Atta Parent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

Informant Frank L Becker

(Address) 413 Grindall St

Filed 11 13 1930 HAMPSON JONES, M. D.

(Title) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 11. 1930

17 I HEREBY CERTIFY, That I attended deceased from 11, 8, 1930, to 11. 11. 1930, that I last saw him alive on 11. 11. 1930, and that death occurred, on the date stated above, at 12.35 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Primary

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L J Darlington M. D.

11. 12. 1930 (Address) 2102 Mt Holly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 11/13 1930

20 UNDERTAKER Tom Cook

ADDRESS 1217 St Paul St

M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

62321 × 171 E 62321

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST. 4-7 WARD)

2-FULL NAME Edward J. Walsh.

(a) RESIDENCE No 2131 Pennsylvania Ave. Washington D.C. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred en route. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

If married, widowed, or divorced HUSBAND of Ethel Walsh.

DATE OF BIRTH (month, day, and year) March 17, 1896

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	7	27	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Physician.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) New York.

10 NAME OF FATHER John E. Walsh.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary M. Roche.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Richard T. Walsh. (brother)

(Address) 2131 Pa. Ave. Washington, D.C.

15 Filed ..... 192 ..... HAMPSON JONES, M. D. Registrar

131930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 13, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Paraldehyde poisoning, Overdose, Occidental.

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Pa. R. R. Station Balto November 11, 1930

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) ..... Coroner, M. D.

11/13/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C.

DATE OF BURIAL Nov 15 1930

20 UNDERTAKER W. J. Tickner & Sons

ADDRESS North & Pa

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62322 — 90 — B-62322

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No.) 3212 Ingleside Ave (St.) 21-55 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Annie Knowles

(a) RESIDENCE NO. 3212 Ingleside Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Widow.

(If married, widowed, or divorced) HUSBAND of (or) WIFE of Thomas Knowles.

DATE OF BIRTH (month, day, and year) Sept. 15 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland.

10 NAME OF FATHER Jno. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

Informant Mr. Harry Kogelschatz

(Address) 3212 Ingleside Ave

Filed NOV 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12th 1929 to Nov 12 1930, that I last saw her alive on Nov. 12th 1930, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Apoplexy & Paralysis of Right side

5 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Val. Heart Dis.

(duration) 2 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Smith M. D.

11/13, 1930 (Address) 1605 N. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL Nov. 14, 30

20 UNDERTAKER Wm. Tuckner Sons ADDRESS North Ave.

12-5-25—A Co.—20 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

323

CERTIFICATE OF DEATH.

129 ✓ E 62323

REGISTERED NO.

1-PLACE OF DEATH

of BALTIMORE: (No. 400 N. Fulton Ave St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bell

(a) RESIDENCE NO. Home for Aged of the M E Church Ward

(Usual place of above) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

DATE OF BIRTH (month, day, and year) Nov. 23. 1848

AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	81	11	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Florist

(c) Name of employer

BIRTHPLACE (city or town)

(State or country) Baltimore Md.

10 NAME OF FATHER Jno H. Bell.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Gaes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

Informant Miss Etta Cuddy 2nd nr St

(Address) 400 N. Fulton Ave

Filed C. HAMPSON JONES, M. D.

3 1930 By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1930

17 I HEREBY CERTIFY, That I attended deceased from ~~Oct~~ Nov 17 1930, to Nov 12, 1930, that I last saw him alive on Nov 10, 1930, and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ✓ yrs. ✓ mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Methods

(Signed) George E. Hamman, M. D.

11/2, 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery Date of Burial Nov 14 1930

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

1-30—M. & T.—250 Bks

62324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62324

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH Baltimore City Hospitals

OF BALTIMORE: (No. 7-12 ST., WARD)

FULL NAME Charles Richards

RESIDENCE NO. 821 N. Milton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Richards

DATE OF BIRTH (month, day, and year) April 3, 1869

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61	60	7	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Checking garbage carts

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer City of Balto.

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Marianne Carlson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Records of Balto. City Hosp.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11-30

17 I HEREBY CERTIFY, That I attended deceased from 3-11-30, 19 , to 11-11-30, 19 ,

that I last saw him alive on 11-11-30, 19 ,

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Heart Disease - Arteriosclerotic

Arteriosclerosis - general

(duration) 1 yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Gus Steinbeck Jr M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

UNDERTAKER Henry Sander & Sons Inc.

DATE OF BURIAL Nov. 14 1930

ADDRESS Baltimore St & Broadway.

NOV 13 '30

Registrar — HARRY JONES, M.

1-30—M. & T.—250 Blks.

Krakora. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

62325 E 62325

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH Sinai Hospital

a) OF BALTIMORE: (No. Monument and Rutland ST., 7-12 WARD)

2. FULL NAME Anna Krakora

3. a) RESIDENCE NO. 2718 East Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

b) Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Krakora

7 DATE OF BIRTH (month, day, and year) Nov 12 1884

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46			

OCCUPATION OF DECEASED

8 (a) Trade, profession or particular kind of work Housewife 37

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohmia

10 NAME OF FATHER Not Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Know

12 MAIDEN NAME OF MOTHER not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Know

Informant Charles Krakora Jr

(Address) 2718 E Madison Street

Filed

H. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12, 1936

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1936 to Nov 12, 1936 that I last saw her alive on Nov 12, 1936 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Diabetes - infected Knee -
Phlebitis - Septic Coma -
Bronchs - Pneumonia

(duration) yrs. mos 2 1 ds.

CONTRIBUTORY (Secondary) Diabetes (duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2718 E Madison

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood Culture

(Signed) Wenger Lindsay Daphne M. D.

, 19 (Address) Sinai Hospital - Baltimore -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cemetery — DATE OF BURIAL Nov 15 1936

20 UNDERTAKER August Paresk — ADDRESS 2406 Ashland ave

-1-30—M. & T.—250 Bks

62326 HEALTH DEPARTMENT—CITY OF BALTIMORE 46 E 62326

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No. 523 Ansquith St, ST. 5-8 WARD)

-FULL NAME Ethel Pelovitz

) RESIDENCE NO. 523 Ansquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
th of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

married, widowed, or divorced
HUSBAND of
or) WIFE of Harry Pelovitz

TE OF BIRTH (month, day, and year)

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44			

CCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

IRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant H. Levy
(Address) 1429 E Baltimore St.

Filed 11 13 1930 C. HARTMAN JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Nov 12, 1930, that I last saw h alive on Nov 12, 1930, and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Ovaries

(duration) 1 yr. mos ds.

Exhaustion

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1930

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) M. Baylin M.D.

11/13 1930 (Address) 2040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 11/13 1930

UNDERTAKER Jack Levin — ADDRESS 1429 E Baltimore St.

-1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

327 ✓ X 101-001 E 62327

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No. Church Home & Infirmary St., 6-9 Ward)

-FULL NAME Everett Burchell

) RESIDENCE NO. 612 B. St. ST., WARD Harrows Point, Md.

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Whit.	Single

married, widowed, or divorced (HUSBAND) of (or) WIFE of

TE OF BIRTH (month, day, and year) Sept 2 1901

E Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
29	2	10	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steelworker 079

(b) General nature of industry, business, or establishment in which employed (or employ Bethlehem Steel Co

(c) Name of employer Sparrows Point Md

IRTHPLACE (city or town) (State or country) Nova Scotia

10 NAME OF FATHER Charles Burchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nova Scotia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Hospital Record

(Address)

Filed 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1930, to Nov 12, 1930, that I last saw him alive on Nov 12, 1930, and that death occurred, on the date stated above, at 3:35 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo Ethelbard, M. D.

, 19 (Address) 409 Cannon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sydney Mines Nova Scotia

UNDERTAKER John F Denny

DATE OF BURIAL Nov 13 1930

ADDRESS 715 Light St

2-29-28—L. F. S.—500 Bks.

328 HEALTH DEPARTMENT—CITY OF BALTIMORE 119 E 62328

CERTIFICATE OF DEATH

PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

OF BALTIMORE: (No. 1420 ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME John Lewis

RESIDENCE NO. 1423 Robert St. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

h of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
de	Colored	married

married, widowed, or divorced HUSBAND of (or) WIFE of Roxie Lewis

TE OF BIRTH (month, day, and year) Oct 12, 1880

	Years	Months	Days	If LESS than 1 day, hrs. or min.
E	50	1		

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Stevedore

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) State or country) Va

0 NAME OF FATHER Daniel Lewis

1 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

2 MAIDEN NAME OF MOTHER unknown

3 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

Informant Roxie Lewis

(Address) 1205 N. Carey St

Filed NOV 13 HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1930, to Nov. 12, 1930, that I last saw him alive on 11-12, 1930, and that death occurred, on the date stated above, at 7 20 a m.

The CAUSE OF DEATH* was as follows:

Peri Rectal abscess followed by Lung abscess

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) Hemoptysis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-11-30

Was there an autopsy? Yes Exploratory Laparotomy

What test confirmed diagnosis? Autopsy

(Signed) C. W. Blake, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

20 UNDERTAKER Thomas E. Kelson

DATE OF BURIAL 11/16 1930

ADDRESS 1303 Pennsylvania St

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62329

161-001

62329

CERTIFICATE OF DEATH

REGISTERED NO. 15-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

Y OF BALTIMORE: (No.) 1336 Carey ST., (WARD)

FULL NAME Infant of Mamie Hall Hall Herman

) RESIDENCE NO. 1336 Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

h of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	C	

married, widowed, or divorced
HUSBAND) of
(or) WIFE of

TE OF BIRTH (month, day, and year) 11/10/30.

Years	Months	Days	If LESS than 1 day, hrs. or min.
8 hrs			

CUPATION OF DECEASED

) Trade, profession or rticular kind of work None

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) 1336 Carey
State or country) Md

0 NAME OF FATHER Herman Hall

1 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

2 MAIDEN NAME OF MOTHER Mamie Hall

3 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant Herman Hall

(Address) 1336 Carey St

Filed 13 1930. HARRISON JONES, M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10—30

17

I HEREBY CERTIFY, That I attended deceased from

11/10, 1930, to 11/10, 1930,

that I last saw her alive on 11/10, 1930

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Malnutrition

(doration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bruce Chatten, M. D.

11/11, 1930 (Address) 2134 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

20 UNDERTAKER Thomas E. Kelam

DATE OF BURIAL 11/13 1930

ADDRESS 1303 Pressman St

1-30—M. & T.—250 Bks

62330

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62330

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH Baltimore City Hospitals (T.B.)

Y OF BALTIMORE: (No. ST. 8-13 WARD)

-FULL NAME James Peter Lyons

) RESIDENCE NO. 1613 Hakesley Place ST., WARD

(Usual place of abode)

th of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Single

married, widowed, or divorced HUSBAND of (or) WIFE of

TE OF BIRTH (month, day, and year) Sept. 12, 1894?

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Box factory

(c) Name of employer Unknown

IRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER John Lyons

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

Informant Hospital Records
(Address)

Filed 19 C. HAMPSON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1930, to Nov. 12, 1930, that I last saw h im alive on Nov. 12, 1930, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Jenner, M. D.

11-12 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral bm	11/15/ 1930
20 UNDERTAKER J. J. Moran	ADDRESS 3000 E Balto

1-30—M. & T.—250 Bks

62331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-9-81 62331

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
   (a) CITY OF BALTIMORE, (No.) 431 N. Fakewood (ST.) dwell (WARD)
   (b) FULL NAME Mary J. Neary
   (c) RESIDENCE NO. 431 N. Fakewood (ST.) Ave (WARD)
   (Usual place of abode) (If non-resident give city or town and State)
   (d) Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

6 If married, widowed, or divorced (a) HUSBAND of (or) WIFE of John Neary

7 DATE OF BIRTH (month, day, and year) Oct 2 1860

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70		16	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Co Donegal Ireland

11 NAME OF FATHER Daniel O'Connor

12 BIRTHPLACE OF FATHER (city or town) (State or country)

13 MAIDEN NAME OF MOTHER Mary Blaeh

14 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire

Informant Margaret Neary
(Address) 431 N. Fakewood Ave

Filed 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10/30.

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1930, to Nov. 10, 1930; that I last saw h[illegible] alive on Nov 10, 1930, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (duration) yrs. mos 3. da.

CONTRIBUTORY (Secondary) Hemiplegia (duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C N Meyer Jr, M. D.

12-19 30 (Address) 1500 E 30th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 11/14 1930

20 UNDERTAKER J. J. Moran

ADDRESS 300 E. Baltimore

Rev.—1-10-21—MAT—1500 Blks.

62332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62332

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6702 Rosemont Ave., Raspeburg, ST., 27-4-42 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Henry Yestadt

(a) RESIDENCE NO. 6702 Rosemont Ave., Raspeburg, Md. ST., 27th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Good (Yestadt)

DATE OF BIRTH (month, day, and year) Jan. 24, 1861

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70	69	11	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. of Boiler Department of Bethlehem Steel Co. (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pennsylvania

10 NAME OF FATHER Valentine Yestadt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Elizabeth Sippel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. George H. Yestadt 6702 Rosemont Ave., Raspeburg.

15 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1930 to November 11, 1930, that I last saw him alive on November 11, 1930, and that death occurred, on the date stated above, at 12:50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis and Endocarditis

(duration) 10? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency (sudden termination.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical appearances of organs at autopsy and absence or other pathology.

(Signed) A. L. Wilkinson, M. D.

11/11 1930 (Address) A. L. Wilkinson, 5713 Belair Rd., Raspeburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL 11/14 1930

20 UNDERTAKER J. J. Moran ADDRESS E Balto

8-16-29—L. F. S.—100 Bks.

62333

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62333

CERTIFICATE OF DEATH

X 49

—PLACE OF DEATH U.S. Marine Hospital, REGISTERED NO. 12-51

Y OF BALTIMORE: (No. Baltimore, Md ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Frank Dickerson

a) RESIDENCE NO. Tyaskin, Wicomico Co., Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) Aug. 14, 1878

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	29	

CUPATION OF DECEASED

a) Trade, profession or particular kind of work Engineer

b) General nature of industry, business, or establishment in which employed (or employer) Seaman

c) Name of employer SS B. S. Ford

RTHPLACE (city or town) Tyaskin
(State or country) Maryland

0 NAME OF FATHER William Dickerson

1 BIRTHPLACE OF FATHER (city or town) Tyaskin
(State or country) Md.

2 MAIDEN NAME OF MOTHER Letitia Fisher

3 BIRTHPLACE OF MOTHER (city or town) Tyaskin
(State or country) Md.

Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

3 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 13, 1930

17

I HEREBY CERTIFY, That I attended deceased from February 25, 19 30, to November 13, 19 30,

that I last saw h im alive on November 13, 19 30

and that death occurred, on the date stated above, at 8:25 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) prior to 2-26-30 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of Mar. 4, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory findings

(Signed) Gordon A. Abbott, M. D.

11/13 19 30 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury Md

DATE OF BURIAL Nov. 14 19 30

20 UNDERTAKER Easton Sons

ADDRESS Easton Md

1-30—M. & T.—250 Bks

62334 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62334

CERTIFICATE OF DEATH. X 90

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No.) 1315 n charles ST. 12-14 (WARD)

-FULL NAME Emma Shafer

) RESIDENCE NO. Kennedyville Md ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred _____ yrs. 7 Weeks. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Widowed

~~married~~, widowed, ~~or divorced~~
~~HUSBAND of~~
(or) WIFE of Tilghman Shafer

TE OF BIRTH (month, day, and year) Sept 15th 1852

GE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
78	1	28	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

IRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Augustus Copenhaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Raine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Miss Emma Shafer

(Address) Kennedyville Md

Filed _____, 19 _____ C. HAMPSON JONES, M. D.

3-1930 Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13th 4:55 PM

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930, to Nov 13, 1930,

that I last saw h[illegible] alive on Nov 13, 1930,

and that death occurred, on the date stated above, at 4:55 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 10 mos _____ ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. 10 mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Ora Pallock, M. D.

, 19 (Address) 1110 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL Chester Town Md — DATE OF BURIAL 11/15/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

1-30—M. & T.—250 Bks

Dr. Wm Triplett 1300 W. Lombard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62335

2335

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) 307 S. Woodyear ST. 14-29 WARD

FULL NAME John A. Regler

RESIDENCE NO. 307 S. Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, ~~widowed, or divorced~~

HUSBAND of ~~(or) WIFE of~~ Annie Regler

DATE OF BIRTH (month, day, and year) 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Tool

(c) Name of employer Hayward Bartlett Co

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Conrad Regler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Clara Winfrieng

(Address) 109 S. Carey St

C. HAMPSON JONES, M. D.

Registrar

3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1st, 1929, to Nov. 12, 1930, that I last saw him alive on Nov. 12, 1930, and that death occurred, on the date stated above, at 9:25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocardial degeneration

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. H. Triplett, M. D.

, 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 11/15/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

—M. & T.—100 B—50L

E 62336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 62336

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. St. Joseph Hospital ST., 9-18 WARD)

2-FULL NAME John C. B. Wright

(a) RESIDENCE NO 1008 East North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah E. Wright

DATE OF BIRTH (month, day, and year) Mar 11/1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .. min.
	70	8	0	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Wylie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sarah E. Wright
(Address) 1008 E. North Ave

C. HAMPSON JONES, M. D.
Registrar

3 1930 192

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? XXXXXXX

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Bauer, M. D.
Coroner

Nov 13/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cemetery

DATE OF BURIAL 11/14/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

ec-12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62337 — 161-01 — E 62337

CERTIFICATE OF DEATH.

Registered No.,

1-PLACE OF DEATH

City of BALTIMORE: (No. 3716 E Lombard St. 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Malin Roe Jr.

(a) Residence No. 3716 E Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.)

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day and year) Nov 7/30

AGE, yrs. mos. 6 ds. If LESS than 1 day, hrs. or ~~min.~~?

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

BIRTHPLACE (city or town) (State or Country). Baltimore Md

10-NAME OF FATHER, Albert M Roe

11-BIRTHPLACE OF FATHER (city or town) Norfolk (State or Country). Va

12-MAIDEN NAME OF MOTHER, Lucian M Robinson

13-BIRTHPLACE OF MOTHER (city or town) Norfolk (State or Country). Va

14-(Informant) albert m Roe

(Address) 3716 E Lombard St

15-Filed NOV 23 1930

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 17/30

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1930 to Nov 17 1930, that I last saw ~~him~~ alive on Nov 17 1930, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth (7 Mo)

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Examination

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Institution

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J M Shepherd M. D.

11/13. 1930 (Address) 3307 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cemetery Hartford Rd. DATE OF BURIAL, Nov. 14, 1930

20-UNDERTAKER. Elmer W. Conklin ADDRESS 924 E. Eager St

E 62338 21 E 62338

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

County Balto City

Balto Md (No. Herring Run Park Sta. 6945 Ward)

Back of Sydenham Hospital in city

2 FULL NAME Phillip T. Forte

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Feb (Month) 7 (Day) 1890 (Year)

7 AGE: 40 yrs. mos. ds. If LESS than 1 day hrs. or min.? 1 4

8 OCCUPATION
a) Trade, profession or particular kind of work: chauffeur
b) General nature of industry, business, or establishment in which employed or (employer): 073

9 BIRTHPLACE (State or country): Balto Md.

10 NAME OF FATHER: Geo Forte

11 BIRTHPLACE OF FATHER (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rebecca Stanley

13 BIRTHPLACE OF MOTHER (State or Country): Balto Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Phyllis Forte

(Address) Herring Run Pk

Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

If more blanks are needed, apply to Local Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 11 (Month) (Day) 1930 (Year)

Nov 1

17 I HEREBY CERTIFY, That I attended the deceased from Nov 1 1930 to Nov 11 1930

that I last saw h alive on Nov 8 1930

and that death occurred on the date stated above, at 3P m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

Contributory Secondary: none

(Duration) yrs. mos. ds.

(Signed) Gertrude Kieffer M. D.

Nov 13 1930 (Address) 1927 E Baltimore St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cem

DATE OF BURIAL: 11-14 1930

20 UNDERTAKER: A Rusk

ADDRESS: 6405 Eastern

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62339

CERTIFICATE OF DEATH.

E 62339

REGISTERED NO. 118

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No.) St. Joseph Hosp ST., 9-46 WARD)

-FULL NAME Rose Keating

a) RESIDENCE NO. 838 E 20th St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married.

married, widowed, or divorced
HUSBAND of
or) WIFE of Thomas F. Keating

ATE OF BIRTH (month, day, and year) May 17 18 5

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	5	25	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Charles McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridgit Sweeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Thomas F. Keating

(Address) 838 E. 20th St

1930 JOSEPH JONES, M. D.

..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1930, to Nov 11, 1930.

that I last saw her alive on Nov 11, 1930.

and that death occurred, on the date stated above, at 9 50 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction
strangulated post-operative
Lenia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/11/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) J B Kelly M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Nov 14 1930

UNDERTAKER Margaret J. Flynn

ADDRESS 1111 Light St.

1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 62340

62340

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

(a) CITY OF BALTIMORE: (No.) 1832 Bolton ST. 14-20 (WARD)

2. FULL NAME Lizzie Kate Banty

(a) RESIDENCE NO. 1832 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of Single

7 DATE OF BIRTH (month, day, and year) abt 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 72	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Dr. Edward Banty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Malinda Coblentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middletown Md.

Informant (Address) Mrs. Stella B. Evans (sister) 1832 Bolton St.

Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/12/30

17 I HEREBY CERTIFY, That I attended deceased from 11/9, 1930, to 11/12, 1930, that I last saw her alive on 11/12, 1930, and that death occurred, on the date stated above, at 9 45 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. B. Hubbard M. D.

11/12, 1930 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov 14/30

UNDERTAKER Stewart & Mowen Co. ADDRESS 108 W. North Avenue

1-30—M. & T.—250 Bks.

62341 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62341

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No. Sinai Hospital ST. 15-68 WARD)

2-FULL NAME Ida Trames

(a) RESIDENCE NO. 1701 N. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

married, widowed, or divorced HUSBAND of or) WIFE of Edward Farmer

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40				

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Harry Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Bank St

15 Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1930, to Nov. 13, 1930,

that I last saw h[illegible] alive on Nov 13, 1930,

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Milton B. Kirsh, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel

DATE OF BURIAL 11-14 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Bank

—M. & T.—100 B—50L

62342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 62342

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 609 W. Lanvale ST. 17-24 (WARD)

2-FULL NAME Jas Ashby.

(a) RESIDENCE NO. 609 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown 1925

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Wm Ashby.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lafayette Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wm Ashby

(Address) 609 W. Lanvale

15 Filed ... 192 ... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) J. H. Funk, M. D. Coroner

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL 11-14 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1725 Ashland Ave

—M. & T.—100 B—50L

E 62343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62343

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3402 Keynon Ave ST. 26-40 WARD)

2-FULL NAME John W. Reese

(a) RESIDENCE NO 3402 Keynon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Elsa M. Reese

DATE OF BIRTH (month, day, and year) June 28/1888

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	5	16	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dispatcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Yellow Cab Co

BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER John Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Nellie Keys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Elsa M. Reese
(Address) 3402 Keynon Ave

15 Filed 12 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ni. death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Indugestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Carew, M. D. Coroner

Nov. 13/30 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Nov. 15 1930

20 UNDERTAKER George W. Dinkler

ADDRESS 1737 E. Eager

1-30—M. & T.—250 Bks

E 62344 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62344

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No. 5922 York Road ST. 17-46 WARD)

-FULL NAME Joseph V. Turecek

a) RESIDENCE NO. 5922 York Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, widowed, or divorced HUSBAND of or) WIFE of Anna

ATE OF BIRTH (month, day, and year) April 1 1877

GE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
53	7	11	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ladies Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Czechoslovakia

10 NAME OF FATHER Joseph Turecek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czechoslovakia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czechoslovakia

Informant Anna Turecek
(Address) 5922 York Road

DEC 4 1930 HARRISON JONES, Registrar, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 01/30.

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to Nov 11, 1930, that I last saw h[illegible] alive on Nov 10, 1930 and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Ch Myocarditis - Ch Dil Nephritis -
Stok Adam Syndrome -
Chronic Endocarditis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Aorto Cardiac Obtitation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings X-Rays

(Signed) E. K. Burkhart, M. D.

12/2, 19 30 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov 15 1930

ADDRESS 1737 E Eager

20 UNDERTAKER George W. Zirkle

—10-10-29—A Co.—100 Bks.

E 62345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74001 E 62345

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 418 Delchester St. 12-50 Ward)

2-FULL NAME Nathaniel Isaac Stokes

(a) RESIDENCE NO. 418 Delchester St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	W	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Dorcas Stokes

DATE OF BIRTH (month, day, and year) 3-14-80

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50	7	28	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Builder
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

8 BIRTHPLACE (city or town) Marion Co
(State or country) S. C.

PARENTS

10 NAME OF FATHER N. Stokes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Jessie Clark

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. C.

14 Informant Dorcas Stokes
(Address) 418 Delchester St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test (confirmed diagnosis)?

(Signed) Chas. Norris, M. D.

1930 (Address) 7632 Richmond ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem.

DATE OF BURIAL Nov. 14 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager St

NOV 14 1930 C. HAMPSON JONES, M. D.

Reg

1-30—M. & T.—250 Bks.

E 62346

HEALTH DEPARTMENT—CITY OF BALTIMORE

108

E 62346

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

a) OF BALTIMORE, (No. Caroline & Lizzr ST., 10-14 WARD)

2-FULL NAME Mrs Margaret Moylan

3a) RESIDENCE NO. 841 Forrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

3b) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	Married

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of Maurice Moylan

7 DATE OF BIRTH (month, day, and year) June

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54			

OCCUPATION OF DECEASED

8a) Trade, profession or particular kind of work House wife

8b) General nature of industry, business, or establishment in which employed (or employer)

8c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Thos. Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt. Power

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Maurice Moylan

(Address) 841 Forrest St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1930, to Nov. 12, 1930.

that I last saw h[illegible] alive on Nov 12, 1930

and that death occurred, on the date stated above, at 11 55 A.m.

The CAUSE OF DEATH* was as follows:

Suppurative Parotitis (left side)

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of Nov 10, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. Messina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Nov 15 1930

20 UNDERTAKER Rita Friedfeld

ADDRESS 114 Gruno[illegible]

1930 HAMPSON JONES, M. D.

1-30—M. & T.—250 Bks.

E 62347 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 62347

CERTIFICATE OF DEATH.

REGISTERED NO. 25-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No. 2401 Kloman ST. WARD)

2-FULL NAME THOMAS KAIRIS

(a) RESIDENCE NO. 2401 Kloman Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 41 yrs. * mos. ds. How long in U. S., if of foreign birth? yrs. * mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

married, widowed, or divorced HUSBAND of or) WIFE of Anna Urbanavicius

ATE OF BIRTH (month, day, and year) No. 1871

AGE	Years	* Months	* Days	If LESS than 1 day, ...hrs. or ....min.
	59			

OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Lithvania

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

Informant Vincent Kairis

(Address) 2401 Kloman Street

Filed 1-4 1930 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 13. 1930 to Nov 13. 1930

that I last saw him alive on Nov 12. 1930

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. F. Hemkmann M.D.

4/4 1930 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov. 15. 1930

20 UNDERTAKER John Grebliauckas — ADDRESS 423 S Paca St

—9 30—A. & Co.—250 Bks.

E 62348

E 62348

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 13-52 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.) 842 West 34th St. (WARD) 13

2 FULL NAME James A Somerville

(a) RESIDENCE NO. 842 West 34th St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) Lulie E Somerville

DATE OF BIRTH (month, day, and year) Dec 23 1861

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
68	10	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Ret

(c) Name of employer

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Jno Somerville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs Lulie E Somerville (wife)

(Address) 842 W 34th st

15 [illegible] C. HAMPSON JONES, M. D. Registrar

141830

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13th 1930

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 13, 1930

that I last saw him alive on Nov. 12, 1930

and that death occurred, on the date stated above, at 1.30 PM

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & arteriosclerosis.

2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? 842 W. 34th St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W. H. Smith M. D.

Nov. 19 (Address) 8427 Chestnut Ls

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Nov 17 1930

20 UNDERTAKER J. Walter Davis

ADDRESS 3rd & Chestnut, Ldv

1-30—M. & T.—250 Blks

62349

HEALTH DEPARTMENT—CITY OF BALTIMORE

62349 E

CERTIFICATE OF DEATH.

129

REGISTERED NO. 18-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

-PLACE OF DEATH

OF BALTIMORE: (No.) 34 So Eoppleton ST. 18 WARD

-FULL NAME Hannah G. Cooke.

(a) RESIDENCE NO. 34 So Eoppleton WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	female. white	Widow.

married, widowed, or divorced
HUSBAND of
or) WIFE of Eugene O. Cooke.

TE OF BIRTH (month, day, and year) March 31-57

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73	7	12 11	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

IRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER John T. Fleteher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rachel Horton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey.

Informant Mrs Mary L Cooke.

(Address) 34 So Eoppleton St

Filed ... 19 C. HAMILTON JONES, M. Registrar

41930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 10. 1930. to Nov 12. 1930.

that I last saw h alive on Nov 12 1930.

and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

11/13, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 11/15/1930

UNDERTAKER John Howard & Son

ADDRESS Gorsuch

1-30—M. & T.—250 Blks

62350 E 62350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Jewish Memorial Hospital

CITY OF BALTIMORE (NO. 1000 Eaton Ave ST. 8-45 WARD)

2-FULL NAME Mrs Katherine M. Tankersley

3(a) RESIDENCE NO. 2827 Lake Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of the late George Hansmann

7 DATE OF BIRTH (month, day, and year) Nov 27-1861

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	7	18	17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Francis Bockstie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Josephine Neraver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

Informant Mrs. C. M. Kapf

(Address) 2827 Lake Ave Balto Md

Filed NOV 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14/1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1930, to Nov 13, 1930, that I last saw her alive on Nov 12, 1930, and that death occurred, on the date stated above, at 7:20 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma of lungs bowel Cryptogenic Synovial sarcoma Colon

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 11/17/1930

20 UNDERTAKER Chas Howard & Son

ADDRESS 901 Holliday St.

—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62351

CERTIFICATE OF DEATH

154-002 E 62351

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

ty of Baltimore: (No. 2019 Spark St. 3-4 Ward)

2-FULL NAME Robert M Jackson

(a) RESIDENCE NO. 2019 Spark St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
mal	wht	Sngle

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			3½	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Monroe Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Florida

12 MAIDEN NAME OF MOTHER Pearl Burrowsk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto City

14 Informant Monroe Jackson
(Address) 2019 Spark St

V 1 4 1930 HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy Hydramnion
Ovarit

(duration) yrs. mos. 3½ ds.

CONTRIBUTORY (Secondary) Congenital

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James W Funk M. D.

11/13/30 19 (Address) 702 Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natore of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem DATE OF BURIAL Nov 14 1930

20 UNDERTAKER John M Ekbery ADDRESS 401 d Chester Av

—10-10-29—A Co.—100 Bks.

62352

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 P 62352

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

(a) City of Baltimore: (No.) Balt City Hospital St. 76-37 (Ward)

2-FULL NAME Frank J. Wieber

(a) RESIDENCE NO. 3922 East ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Wieber

DATE OF BIRTH (month, day, and year) Dec 17 1863

AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	10	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mr

(b) General nature of industry, business, or establishment in which employed (or employer) Brushes

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown Wieber

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Frances Wieber

(Address) 3922 East ave

15 Filed 1-4-1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H. Pinkham, M. D.

Mch 4 1930 (Address) 7002 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Nov 17 1930

ADDRESS 1737 E. Eager

20 UNDERTAKER George W. Zinkler

.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62353

CERTIFICATE OF DEATH

88 V E 62353

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

(y of Baltimore: (No. 418 W. Lexington St. 6-11 Ward)

2 FULL NAME William Beck

(a) RESIDENCE NO. 2904 Orleans St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced (or) WIFE of late Frances Beck

6 DATE OF BIRTH (month, day, and year) Apl 20/68

7 AGE	Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
	62	6	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Frank Beck

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaut

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. John H. Johnson
(Address) 2904 Orleans St

14 1930 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feltz M. D.

11/13, 1930 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Nov 15 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103

62354

E 62354

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

62354

-PLACE OF DEATH

Y OF BALTIMORE: (No. 2023 N. Smallwood St. 12-20 WARD)

-FULL NAME Ann R. Harris

(a) RESIDENCE NO. 716 E. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widow

married, widowed, or divorced (or) ~~HUSBAND~~ WIFE of late John P. Harris

ATE OF BIRTH (month, day, and year) May 28/48

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	5	15	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER John J. McNeir

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Melvina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bermuda Island

Informant Edmund P. Harris Jr

(Address) 716 E. North Ave

Filed 4 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/30

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to Nov 12, 1930.

that I last saw her alive on Nov 12, 1930 and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Infirmities

(duration) several yrs. mos 3 da.

CONTRIBUTORY (Secondary) Infirmities of age

(duration) years yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Chemical

(Signed) C. O. Carman M. D.

11-13 1930 (Address) 1701 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

20 UNDERTAKER Philip Henry

DATE OF BURIAL Nov 15 1930

ADDRESS 2016 Orleans St

1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62355 3/VE 62355

CERTIFICATE OF DEATH.

REGISTERED NO. 27-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) Union Memorial Hospt. ST. WARD

2-FULL NAME Miss M. Clare Wicks

(a) RESIDENCE NO. 3406 Boneraft Rd. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) June 15 1879

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51	51	4	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Delaware

10 NAME OF FATHER Benjamin Chambers Wicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hanaber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Sister Miss Lucy Wicks

(Address) 3406 Boneraft Rd. Baltimore, Md.

Filed NOV 4 1930 C. Harrison Lapp Registrar

MEDICAL CERTIFICATE OF DEATH 13

16 DATE OF DEATH (month, day, and year) 11/13/30

17

I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1930, to Nov. 13, 19....,

that I last saw her alive on Nov. 13, 1930,

and that death occurred, on the date stated above, at 16:15 P.m.

The CAUSE OF DEATH* was as follows:

Appendicitis with perforation - Tuberculer in origin - Pelvic - Peritonitis - Intestinal obstruction

(duration) ? yrs. mos. ds.

CONTRIBUTORY - (Secondary) Pulmonary Tbc

(duration) ? 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 10-25-30 & 11-9-30

Was there an autopsy? yes

What test confirmed diagnosis? operation - autopsy

(Signed) Richard T. Chamberlain, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old St Paul Cem Lot C and 15 DATE OF BURIAL Nov 15 1930

20 UNDERTAKER John O Mitchell & Son ADDRESS 911 Eutaw Place

8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62356 90 E 62356

CERTIFICATE OF DEATH

REGISTERED NO.

—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (No. 2426 Liberty Heights Ave. 15-58 WARD)

—FULL NAME Ella V.L.Elliott

a) RESIDENCE NO. 2426 Liberty Heights Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

rth of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Widow

married, widowed, or divorced
HUSBAND of (or) WIFE of William H.Elliott

ATE OF BIRTH (month, day, and year) Aug.9.1843

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	3	4	

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work Retired

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

IRTHPLACE (city or town) Md.
(State or country)

10 NAME OF FATHER Wm.I.Layfield

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant Marion L.Elliott

(Address) 2426 Liberty Heights Ave

Filed 19

C. HAMPSON JONES, M.D.
Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov.12.1930

17 I HEREBY CERTIFY That I attended deceased from Oct. 30, 1930, to Nov. 12th, 1930, that I last saw her alive on Nov. 12th, 1930, and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis Senility

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Bulkley M. D.

, 19 (Address) 1211 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov.15.1930

20 UNDERTAKER John O.Mitchell & Sons

ADDRESS 1900 Eutaw Place

John O. Mitchell & Sons

—1-30—M. & T.—250 Blks

62357 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62357

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1.-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3725 Elm ave ST. 13-52 WARD)

2.-FULL NAME Dwilton F Wilson

(a) RESIDENCE NO. 3725 Elm ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

6 If married, widowed, or divorced (or) HUSBAND of (or) WIFE of Single Jan

7 DATE OF BIRTH (month, day, and year) 11 Dec 1874

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) 057

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Baltimore Md

11 NAME OF FATHER William H. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Margaret Hartley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Adelaide Wilson

(Address) 3725 Elm Ave.

C. HAMPSON JONES, M.

Filed ..... 19..... Registrar

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 1930, to Nov 14 1930, that I last saw h[illegible] alive on Nov 14 1930, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows: Cancer of Intestines Paralysis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Senile Debility (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & symptoms

(Signed) [illegible] M. D.

11/15/30 (Address) 701 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov 15 1930

20 UNDERTAKER Frank V. Pistone

ADDRESS 1800 E. 32nd st

—1-30—M. & T.—250 Bks

62358 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 62358

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No. 1220 N. Milton Ave ST. 8-12 WARD)

2-FULL NAME Rosalia Vazzana

(a) RESIDENCE NO. 1220 N. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widow

married, widowed, or divorced HUSBAND of or) WIFE of Lawrence Vazzana

ATE OF BIRTH (month, day, and year) Jan 28, 1860

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		15	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —none—

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

IRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Salvatore Maggione

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Marianna Rosso

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Marian Vazzana

(Address) 1220 N. Milton Ave

4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13-30

17 I HEREBY CERTIFY, That I attended deceased from 8-13-, 1930, to 11-13, 1930, that I last saw h[illegible] alive on 11-12, 1930, and that death occurred, on the date stated above, at 7. a. m.

The CAUSE OF DEATH was as follows:

Acute pleurisy — with effusion & Emphysema

Chronic hypertension heart — Valvular [illegible] (duration) ? yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Emphysema — (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical —

(Signed) S. J. Simarco, M. D.

11-13 1930 (Address) Medical Art Bldg —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov 17 1930

ADDRESS 2818 E. Balto

20 UNDERTAKER Frank V. Palatone

Spec.—1-10-21—M&T—1500 Bks.

62359

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62359

CERTIFICATE OF DEATH.

44

REGISTERED NO. 11-24

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 810 Cathedral St. (Ward) JOHNSON

2-FULL NAME Robert Wilkinson

(a) RESIDENCE NO. 810 Cathedral St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia W. H. Johnson

7 DATE OF BIRTH (month, day, and year): Sept 8-1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Md

PARENTS

10 NAME OF FATHER: William Fell Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co Md

12 MAIDEN NAME OF MOTHER: Ann Mifflin Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila Pa

14 Informant (Address): Robert W Johnson Jr 4 E. Madison St

15 Filed: NOV 14 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13 1930

17 I HEREBY CERTIFY, That I attended deceased from August 17, 1930, to November 13, 1930, that I last saw him alive on November 13, 1930 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency (duration) yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Dr. S. M. B. Jones confirmed Diagnosis.

(Signed) Thomas B. Julian, M. D.

, 19 (Address) 1201 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Thomas Garrison Forest — DATE OF BURIAL: Nov 15 1930

20 UNDERTAKER: Henry W Jenkins & Son — ADDRESS: 60 Edward & 1100 Eutaw

—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62360

CERTIFICATE OF DEATH.

E 62360

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (NO.) 1035 N Eutaw ST. (WARD) 11-24

2-FULL NAME Silas Martin

(a) RESIDENCE NO. 1035 N Eutaw ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: Male | 4 COLOR OR RACE: Color | 5 Single, Married, Widowed, or Divorced: Widower

If married, widowed, or divorced: HUSBAND of (or) WIFE of Amanda Mack

DATE OF BIRTH (month, day, and year) 1882

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Geo. Moore
(Address) 2231 N Preston St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1930, to Nov 12, 1930, that I last saw him alive on Nov 11, 1930, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

36 hours
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) None
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. C. Patterson ..... M. D.

..... 19 (Address) 417 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn Evergreen — DATE OF BURIAL: Nov 15 1930

20 UNDERTAKER: John C. Miller — ADDRESS: 2435 E Oliver

2-29-28—L. F. S.—500 Bks.

E 62361

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-03

E 62361

CERTIFICATE OF DEATH

—PLACE OF DEATH Childen's Hospital School REGISTERED NO. .....

Y OF BALTIMORE: (No. ..... ST., 8-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Margaret Ellen Gross

) RESIDENCE NO. 1818 Register St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 5 yrs. 9 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) Jan 28 1925

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	9	15	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work None

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Baltimore
tate or country) Md.

0 NAME OF FATHER Joseph F. Gross.

1 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

2 MAIDEN NAME OF MOTHER Margaret Elder Mansfield

3 BIRTHPLACE OF MOTHER (city or town) Cockeysville
(State or country) Md

Informant Mrs Margaret Ellen Gross

(Address) 1818 Register St.

Filed 1-4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12-30

17

I HEREBY CERTIFY, That I attended deceased from Nov 4, 1930, to Nov 12, 1930,

that I last saw her alive on Nov 12, 1930

and that death occurred, on the date stated above, at 6 25 P. m.

The CAUSE OF DEATH* was as follows:

Spastic Paraplegia, Congenital

(duration) 5 yrs. 9 mos. 15 ds.

CONTRIBUTORY (Secondary) Shock following craniotomy

(duration) 0 yrs. 0 mos. 0 ds. 8 hrs.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of 11/12/30

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam. only

(Signed) T. Campbell Thompson M. D.

, 19 (Address) Childen's Hospital School

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 11-15 1930

20 UNDERTAKER J. Rust

ADDRESS 5705 Sinclair

c.—9-30—A. & Co.—250 Blks

62362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-004 62362

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.) 708 N. Collington Ave (WARD) 4-12

2 FULL NAME Louis F. Holland

(a) RESIDENCE NO. 708 N. Collington Ave. (WARD) —

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6 If married, widowed, or divorced: HUSBAND of (or) WIFE of Emily Holland

7 DATE OF BIRTH (month, day, and year) Dec. 31/1877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Asbestos Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (state or country) Balto. Md.

10 NAME OF FATHER Louis M. Holland.

11 BIRTHPLACE OF FATHER (city or town) (state or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Emma Brady.

13 BIRTHPLACE OF MOTHER (city or town) (state or country) Howard Co.

14 Interment (Address) Emily Holland 708 N. Collington Ave.

15 [illegible] 4 1930

16 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-30

17 I HEREBY CERTIFY, That I attended deceased from 11-5-30 to 11-6-30 that I last saw h[illegible] alive on 11-5-30 and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation 1

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ford Dorsey M.D.

(Address) 1008 Mt. St.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

20 UNDERTAKER: C. Miller & Son

DATE OF BURIAL: Nov. 11 1930

ADDRESS: 2334 Jefferson St.

—1-12-23—M&T—500 Blks.

62363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 120 E 62363

REGISTERED NO. .....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Volunteer's Hospital 425 ST. ..... WARD)

2-FULL NAME Catherine Corridean Wharton

(a) RESIDENCE NO. Elkton, Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	~~Single~~ Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	35			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Harry Corridean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Albert Corridean

(Address) 116 E. Franklin St. Richmond

15 Filed 1930 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 — 14 1930

17 I HEREBY CERTIFY, That I attended deceased from 10 — 18, 1930, to 11 — 14, 1930

that I last saw her alive on 11 — 14, 1930

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute Yellow atrophy of Liver

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory tests

(Signed) A. J. Conrey, M. D.

11-14, 1930 (Address) Vol. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton, Md.

DATE OF BURIAL 11/14/30

20 UNDERTAKER Harry F. Leitzke, 41 E. Lemon St. Agt.

ADDRESS

1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62364

62364

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 McCulloh ST. 14th WARD)

2-FULL NAME Sampson Layfield

(a) RESIDENCE NO. 1423 McCulloh ST., 14th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of or (1) WIFE of: Louise Layfield

DATE OF BIRTH (month, day, and year): March 17 1851

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	7	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Reiser

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Salisbury Md

10 NAME OF FATHER: Alfred Layfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Salis Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Somerset Co Md

Informant: Louise Layfield

(Address) 1423 McCulloh St

Date: 1 4 1930 Filed: Par

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/12 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/11, 1930, to 11/12, 1930,

that I last saw h[illegible] alive on 11/12, 1930,

and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Wm. Pickett, M. D.

, 19 (Address) 729 Hartford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn Cem

DATE OF BURIAL: Nov 15 1930

20 UNDERTAKER: John H Owens

ADDRESS: 538 Dolphin St

—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62365

CERTIFICATE OF DEATH

90 E 62365

REGISTERED NO.

1.—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1623 Linden Avenue ST., 14-70 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2.—FULL NAME John Hamilton Caughy

(a) RESIDENCE NO. 1623 Linden Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 14 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced
HUSBAND of (or) WIFE of Laura V. Mittnacht

6 DATE OF BIRTH (month, day, and year) March 30, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER John H. Caughy

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth A. Caughy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Mrs. Hamie C. Funston

(Address) 3012 N. Calvert Street

Filed C. HAMPSON JONES, M. D. Registrar

4 1930 — RAA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 28 1930, to Nov 14 1930

that I last saw him alive on Nov 13 1930

and that death occurred, on the date stated above, at 6:15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis —

(duration) Since

CONTRIBUTORY (Secondary) Bronchio-Pneumonia — (duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No — Date of

Was there an autopsy? No —

What test confirmed diagnosis? None

(Signed) Chas W Lynch, M. D.

Nov 15 1930 (Address) 1327 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 11/15 1930

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

C.—9-30—A. & Co.—250 Bks.

(Nellie Hoover)

62366 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62366

CERTIFICATE OF DEATH.

REGISTERED No. 129

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood (Sanatorium) 12-50 WARD)

2. FULL NAME Nellie Hoover (Emma Nee Henry)

(a) RESIDENCE No. 210 E 31st St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
(or) WIFE of Otis Hoover

DATE OF BIRTH (month, day, and year) 6-29-1885

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	4	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER James Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co

14 Informant (Address) Mrs O Hoover 210 E 31st St Balto

15 Filed ..... 19 HARRISON JONES, M. Registrar

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-12-30

17 I HEREBY CERTIFY. That I attended deceased from Apr 1st, 19 30, to Nov-12, 19 30

that I last saw h alive on Nov-11, 19 30

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy + Hemiplegia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? (No) Date of

Was there an autopsy? (No)

What test confirmed diagnosis? By symptoms

(Signed) H. Stanley Grogan M.D.

(Address) 700 St Paul

Nov 15, 19 30

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Nov 15 1930

20 UNDERTAKER Mary M Wiedefeld — ADDRESS 501 E 22nd St

r.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62367

CERTIFICATE OF DEATH

E 62367

REGISTERED NO. E 62367

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

ity of Baltimore: (No. 3016 Oakley or St. 27-55 Ward)

2-FULL NAME William F. Bowling

(a) RESIDENCE NO. 3614 Oakley or St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	W	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Bowling

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	57	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Towson
(State or country) Md

PARENTS

10 NAME OF FATHER C. F. Bowling

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah V. Simmons

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Co. Md

14 Informant Sarah A. Bowling
(Address) 3614 Oakley Ave

19 1930 E. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Valvular disease of heart

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11/13 1930 (Address) 2622 Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL 11/15 1930

20 UNDERTAKER C. Vernon Lemmon

ADDRESS 4611 Park Heights Ave.

—1-30—M. & T.—250 Bks

62368 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62368

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

Y OF BALTIMORE: (NO. ST., 14-28 WARD)

2-FULL NAME Catherine Ross

(a) RESIDENCE NO. 59 S. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

ATE OF BIRTH (month, day, and year) Oct. ?

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Records of

(Address) Balto. City Hosp.

5 ...ber 4 1930 ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13-30

17 I HEREBY CERTIFY, That I attended deceased from 11-5-30, 19..., to 11-13-30, 19...,

that I last saw h... alive on 11-13-30, 19...,

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease.
Arteriosclerotic
unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/16/1930

20 UNDERTAKER Wm Cook 1217 E Fayette St

ADDRESS

—1-30—M. & T.—250 Bks

Dr Schlenger 3034 E Balto St Dud 3574

62369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 62369

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Lakewood Ave. St. 6-10 WARD)

2-FULL NAME Henry Corson

(a) RESIDENCE NO. 108 N. Lakewood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

If ~~married, widowed,~~ or divorced HUSBAND of ~~or WIFE of~~ Evelyn

6 DATE OF BIRTH (month, day, and year) Dec 21st 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O&O

(c) Name of employer Can Co

9 BIRTHPLACE (city or town) (State or country) Balto md

10 NAME OF FATHER Henry Corson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Katharina Uelslager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lillie Gettamüller

(Address) 108 N. Lakewood ave

15 Filed NOV 14 1930 19 ARW Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930 to Nov 13, 1930

that I last saw h~~im~~ alive on Nov 13, 1930

and that death occurred, on the date stated above, at 10 4/10 P m.

The CAUSE OF DEATH* was as follows:

Chr interstitial nephritis

Pontile hemorrhage & paralysis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin data

(Signed) Schlenger M. D.

, 19 (Address) 3034 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 11/14/ 1930

20 UNDERTAKER Mc Cook 1217 E Pratt St

ADDRESS

)—M. & T.—100 B—50L

62370

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 62370

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST. 10-14 WARD)

2-FULL NAME Michael J.Codd.

(a) RESIDENCE NO 1100 E.Biddle St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

DATE OF BIRTH (month, day, and year) August 26,1902

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	2	18	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore,Md.

PARENTS

10 NAME OF FATHER William J.Codd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Elizabeth Cleary.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Marie E.Codd.(sister)

(Address) 1216 St.Paul St.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 13,1930[19]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1100 E. Biddle St.

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Reinhardt, M. D. Coroner

11/14/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/17/1930

20 UNDERTAKER Wm Cook

ADDRESS 1257 St Paul St

—1-30—M. & T.—250 Blks

Dr. Davis
826 N. Fulton Ave

E 62371 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62371

99-00

CERTIFICATE OF DEATH.

REGISTERED NO. 1427

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 620 N. Fulton ST Ave WARD)

2-FULL NAME Emma M. Godman

(a) RESIDENCE NO. 620 N. Fulton ST Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Robert E. Godman

DATE OF BIRTH (month, day, and year) June 12, 1844

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	5	0m	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER James Muir

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Geers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elizabeth Muir
(Address) 1620 N. Fulton Ave

15 Filed ....D., 19.... HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to date of death, that I last saw h— alive on Nov, 13, 1930, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:
Lung Standing Case of Chronic Bronchitis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evd

(Signed) Thomas Lee Davis, M. D.

(Address) 824 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Nov 17 1930

20 UNDERTAKER William Cook — ADDRESS 1212 St Paul

—1-30—M. & T.—250 Bks

Interment 1403 Bartlett

62372 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62372

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1414 Bolton ST., 14-20 (WARD)

2-FULL NAME Harry F. H. Baughman

(a) RESIDENCE NO. 1414 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Florence

DATE OF BIRTH (month, day, and year) Sept 23, 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Government Service

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Michael Baughman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mahalia Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Edith F. Baughman (Address) 1414 Bolton St

Filed 14 1930, 19 HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1930; to Nov 12, 1930; that I last saw him alive on Nov 12, 1930, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis with Hypertension & Arterio-Sclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral & Pulmonary Edema (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Woodby M. D.

, 19 (Address) 140 Hartford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Nov 15 1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 N. Howard St

1-30—M. & T.—250 Blks.

62373 HEALTH DEPARTMENT—CITY OF BALTIMORE F. 62373

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) 204 N 25th ST. 12-51 (WARD)

2-FULL NAME Emma Swann

(a) RESIDENCE NO. 204 N. 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of Thos. A. Swann

ATE OF BIRTH (month, day, and year) Mar 23 1858

GE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	7	19	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) City
(State or country)

10 NAME OF FATHER Philip Smick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Nellie Bussey
(Address) 210 E. 21st St.

Filed 4 1930, 19 HARPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Nov 13, 1930, that I last saw her alive on Nov 13, 1930, and that death occurred, on the date stated above, at 3.10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 days

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Richardson M.D.

Nov 14, 1930 (Address) 112 W. 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 11/15/1930

20 UNDERTAKER E. J. Fanning & Son

ADDRESS 1938 Lafayette Ave.

—1 30—M. & T.—250 Bks

E 62374 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62374

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 14-28 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.

2-FULL NAME Julia Flannigan

(a) RESIDENCE NO. 1812 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (or) HUSBAND of (or) WIFE of James

ATE OF BIRTH (month, day, and year) Sept. 8. 1867

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	2	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER William Irwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridgett Gleason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant (Address) Records of Balto. City Hosp.

1 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12-30

17 I HEREBY CERTIFY, That I attended deceased from 6-30-30, 19.. to 11-12-30, 19.., that I last saw h[illegible] alive on 11-12-30, 19.., and that death occurred, on the date stated above, at 12:05 A. m.

The CAUSE OF DEATH* was as follows:

Heart disease, arteriosclerotic.
Auricular fibrillation.
UNKNOWN.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

11-12, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem.

DATE OF BURIAL 11/15/1930

20 UNDERTAKER Harry N. Lutzke, 1101 E. Monument Ave.

ADDRESS

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62375

129 E 62375

REGISTERED NO.

—PLACE OF DEATH

Y OF BALTIMORE: (No. 3114 Remington Ave (STREET) 12-54 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Mary Jane McLaren

a) RESIDENCE NO. 3114 Remington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

married, widowed, or divorced

~~HUSBAND of~~ (or) WIFE of Robert McLaren

TE OF BIRTH (month, day, and year) Aug 5, 1879

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	3	8	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 027

(c) Name of employer

IRTHPLACE (city or town) (State or country) Balto, Md.

10 NAME OF FATHER W. J. Irwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Robert McLaren

(Address) 3114 Remington

J. HARRISON JONES, M.D. Registrar

Filed ..., 19...

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1928, to Nov. 13, 1930, that I last saw her alive on Nov. 12, 1930 and that death occurred, on the date stated above, at 2 15 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis endocarditis, arteriosclerosis & hypertension, nephritis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical evidence

(Signed) Geo. B. Dyberd, M. D.

, 19 (Address) 2802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Nov 15 30 19

20 UNDERTAKER Harry H. Witzke ADDRESS 4101 Edmondson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62376 — E 62376

CERTIFICATE OF DEATH.

16-00

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Clifton Ave St.: 15-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin L. Lunde.

Residence in Baltimore: No. 2020 Clifton Ave St.: yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, July 8, 1905
(Month) (Day) (Year)

7-AGE, 25 yrs. 4 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Caulker Ln
(b) General nature of industry, business, or establishment in which employed (or employer): Pope Co.

9-BIRTHPLACE, (State or Country). Mayo, Md.

PARENTS.

10-NAME OF FATHER. August Lunde

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Annie Leary.

13-BIRTHPLACE OF MOTHER (State or Country). Anne Arundel Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irwin Lunde

(Address) 2020 Clifton Ave

15-

Filed ..... 191.. C. HARPSON JONES, Registrar.

4 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 14, 1930
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1930, to Nov. 14, 1930, that I saw him alive on Nov. 14, 1930, and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

(Signed) Hugh Forsythe M. D.

11/14, 1930 (Address) 1224 E. Lund Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mayo M. E. Ch

DATE OF BURIAL, Nov. 16, 1930

20-UNDERTAKER L. A. Hopkins

ADDRESS Annapolis

—1-30—M. & T.—250 Bks

62377 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 122-001 E. 62377

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1413 Lynden Ave ST., 14-20 WARD)

2-FULL NAME David Elmer Tuschock

(a) RESIDENCE No. 1413 Lynden Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 6-1874

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
(a)	55	11	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Ag't

(b) General nature of industry, business, or establishment in which employed (or employer) Ramsey - Barry Co

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER J M Tuschock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hayna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Nell Tuschock
(Address) 3038 Guilford Ave

15 Filed ..... 19... C. HARRISON JONES Jr. Registrar

15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 - 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10th, 1930, to November 13th, 1930, that I last saw h... alive on November 13th, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

(duration) ... yrs. ... mos 1 ... ds.

CONTRIBUTORY (Secondary) Cirrhosis of liver (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? clinical diagnosis

(Signed) C B Culbertson M. D.

11/14 1930 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 15 1930

20 UNDERTAKER Wm J Tuckner & Sons

ADDRESS N. & Pa.

...r.—10-10-29—A Co.—100 Bks.

E 62378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62378

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 11-24 Ward)

2-FULL NAME Caddie Conner

(a) RESIDENCE NO. 410 W Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar Conner

6 DATE OF BIRTH (month, day, and year) Unknown 1911

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	19	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) South Carolina

PARENTS

10 NAME OF FATHER James McCray

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Rebecca Givens

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) S. C.

14 *Informant Sarah Weatherspoon
(Address) 410 W. Hoffman St

1930 19 BALTIMORE CITY, MD. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Septic Endocarditis
Carditis
(Acute Rheumatic)
..... (duration) ..... yrs. 1/2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? See P. 17

(Signed) James M Fenton, M. D.

Nov 19 30 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sumpter S. C.

DATE OF BURIAL Nov 15, 1930

20 UNDERTAKER John H Tradin

ADDRESS 1027 Lanvale

130 M. & T.—250 Bks.

62379 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 100-001 REGISTERED NO.

CITY OF BALTIMORE: (No.) Balto. md. ST. 13-52 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Lutman

(a) RESIDENCE NO. 3306 Elm Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced (or) HUSBAND of Mary Lutman

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
36			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gdr

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER George Lutman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Records City Hosps.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-30

17 I HEREBY CERTIFY, That I attended deceased from 10-9-, 1930, to 11-14-, 1930, that I last saw him alive on 11-13, 1930, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis Chronic (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Goldsmith M. D.

11/14 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary Hampden

DATE OF BURIAL Nov 17 1930

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Elmwood

5 T930 AKH

Spec—12-23-21—E.B.R.S.—400 Bks.

62380

HEALTH DEPARTMENT—CITY OF BALTIMORE

62380 E

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1410 W. Lanvale St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Duppins

(a) Residence No. 1410 W. Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Samuel Duppins

6-DATE OF BIRTH (month, day and year): Aug. 31, 1873

7-AGE: 57 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home 041

(b) General nature of industry, business, or establishment in which employed (or employer): Laundress

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Calvert County, Md.

PARENTS.

10-NAME OF FATHER: Jacob Gross

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Calvert County, Md.

12-MAIDEN NAME OF MOTHER: Ellen Harrison

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Calvert County, Md.

14- (Informant): Paul Duppins

(Address): 1410 W. Lanvale St.

15- 19 HAMPSON JONES, M. D. Registrar.

15 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov. 12, 1930.

17- I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1929 to Nov. 11, 1930.

that I last saw h[illegible] alive on Nov. 11, 1930.

and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): none

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John D. Quinn, M. D.

11/12/30 19 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Nov. 15 19 30

20-UNDERTAKER: Virginia A. Brooks

ADDRESS 1460 N. Carey

Spec.—7-17-26—A Co.—200 Bks.

E 62381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62381

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 624 N. Monroe St. St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie J. Charles.

(a) RESIDENCE NO. 624 N. Monroe St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ✓ mos. ✓ ds. How long in U. S. If of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~last~~ WIFE of Jacob F. Charles.

6 DATE OF BIRTH (month, day, and year) July 14-1861

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	69	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired. (Housewife.)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER Wm. Woollen.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Cheesum.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John R. Charles. (Address) 1926 Harlem Ave.

15 1930 ..... 19 ..... Registrar A.K.W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930, to Nov 12, 1930, that I last saw h~~er~~ alive on Nov 12, 1930, and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal.

High Blood Pressure

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

Myocardial Insufficiency (duration) 7 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical,

(Signed) [illegible] M. D.

19 (Address) 586 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Nov. 15-1930.

20 UNDERTAKER Charles J. Schwab ADDRESS 505 N. Monroe St.

ce.—9-30—A. & Co.—250 Blks.

E 62382

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62382

129

CERTIFICATE OF DEATH.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 203 N. Spring St. 5th WARD)

2. FULL NAME Cook, Sarah Ann

(a) RESIDENCE No. 203 N. Spring St. 5th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Widow

6 If married, widowed, or divorced (or) WIFE of Henry Preston Cook

7 DATE OF BIRTH (month, day, and year) April 10, 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Richard Lacwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): U.S.A. ?

12 MAIDEN NAME OF MOTHER Lucy Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U.S.A. ?

14 Informant James Cook

(Address) 203 N. Spring St

15 Filed NOV 15 1930, 19..

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/7, 1930, to 11/12, 1930

that I last saw her alive on 11/12, 1930

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Rayner Browne M. D.

, 19 (Address) 1500 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. A. A. Md. Co.

DATE OF BURIAL: 11-16 1930

20 UNDERTAKER: Byrom & Wright

ADDRESS: 1218 McCulloh St

—1-30—M. & T.—250 Bks.

E 62383 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 62383

49

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. South Balto Gen Hospital ST., WARD)

2-FULL NAME Lucy Tant Ford

(a) RESIDENCE NO. 1620 Mulliken ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Charles Tant Ford

DATE OF BIRTH (month, day, and year) nov. 23- 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant South Balto Gen Hospital (Address)

NOV 15 1930

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1930, to Nov-12, 1930, that I last saw her alive on Nov-7, 1930, and that death occurred, on the date stated above, at 7.50 p.m.

The CAUSE OF DEATH* was as follows:

Luetic cardio-vascular disease with myocardial failure

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) carcinoma of thigh

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Nov-8-1930

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm O'Sullivan, M. D.

, 19 (Address) So Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 11-15 1930

20 UNDERTAKER Byron Wright 1218 N. Eden Alley St

ADDRESS

or.—10-10-29—A Co.—100 Bks.

62384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60-E 62384

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. #2407 E.Federal St. St., 8-16 Ward)

2-FULL NAME Milton H.Bryan

(a) RESIDENCE NO. #2407 E.Federal St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hallie F.Bryan

6 DATE OF BIRTH (month, day, and year) Oct.1st.1881

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer) Un.Ry.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Madison CO.Va.

PARENTS

10 NAME OF FATHER Henry Bryan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Lydia

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Hallie F. Bryan
(Address) 2407 E. Federal St.

15 DEC 15 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency
(duration) yrs. mos. ds.
Hyperthyroidism (Benign)
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. H. Collins, M. D.
Nov 14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 11/16 1930

20 UNDERTAKER Philip Henry 2016 Orleans St.

ADDRESS

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62385 X 124 ✓ E 62385

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Md. Gen. Hospt. St., 11-24 WARD)

2—FULL NAME Harry T. Hayle

(a) RESIDENCE NO. Chestertown - Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~

DATE OF BIRTH (month, day, and year) 1869

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith 006

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

BIRTHPLACE (city or town) (State or country) Pennsylvania

10 NAME OF FATHER Thomas M. Hayle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Annie Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

Informant Mrs Elen M Hayle (wife)

(Address) Chestertown Md

Filed ..... 19 ..... C. HARRISON JONES, Registrar

151930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 30

17 I HEREBY CERTIFY, That I attended deceased from ..... 1930, to Nov 14, 1930, that I last saw him alive on Nov 14, 1930 and that death occurred, on the date stated above, at 10.30 p m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. 10 mos. 14 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Chestertown Md.

Did an operation precede death? yes Date of 11/8/30

Was there an autopsy? no

What test confirmed diagnosis? Urea Retention Clinical

(Signed) James A. Miller, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	Nov. 15 1930
20 UNDERTAKER	ADDRESS
Stewart Mann Co	Balto.

c.—1-30—M. & T.—250 Bks

62386

HEALTH DEPARTMENT—CITY OF BALTIMORE

62386

CERTIFICATE OF DEATH.

REGISTERED NO. 62386

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 18-26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. (Thuder on)

2-FULL NAME Alice Griffin

(a) RESIDENCE NO. 1031 W. Clay st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	Colored	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Sept. 26, 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	1	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress & cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Washington D.C.

10 NAME OF FATHER Randall Thurston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Josephine Halls

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 [illegible] 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1930 to Nov. 11, 1930, that I last saw her alive on Nov. 11, 1930, and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis, acute

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Jenner, M. D.

(Address) Baltimore City Hospitals 11-11-30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 11-15 1930

20 UNDERTAKER Wm Peter R. Williams

ADDRESS 322 N. Schroeder St. Baltimore, Md.

c.—1-30—M. & T.—250 Bks

E 62387 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 62387

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.

2-FULL NAME Mary E. Allen

(a) RESIDENCE NO. 587 Orchard St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Oct. 15, 1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	70			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Gloucester Co. Va.

10 NAME OF FATHER Peter Dobson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emma Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Records of Balto. City Hospitals

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10-30

17 I HEREBY CERTIFY, That I attended deceased from 11-8-30, 19..., to 11-10-30, 19...

that I last saw her alive on 11-10-30, 19...

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease, arteriosclerotic. (duration) yrs. unknown mos ds.

CONTRIBUTORY (Secondary) Auricular fibrillation (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

11, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL 11/15/30

20 UNDERTAKER Edmund Remsby ADDRESS 578 N Bdwy

6 1930

c 1-30—M. & T.—250 Bks

E 62388 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 62388

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Baltimore City Hospitals ST. 11-24 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.

2-FULL NAME Alta Gray

(a) RESIDENCE NO. 890 Linden Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Divorced

If married, widowed, or divorced HUSBAND of or) WIFE of Eddie Neiler

DATE OF BIRTH (month, day, and year) Nov. 23, 1897

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
32	33	11	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Frederick Md.

10 NAME OF FATHER Dennis ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Leila Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of
(Address) Baltimore City Hosp.

Filed 5 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-30

17 I HEREBY CERTIFY, That I attended deceased from 8-26-30, 19, to 11-14-30, 19,

that I last saw h er alive on 11-14-30, 19,

and that death occurred, on the date stated above, at 6:20 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency
(duration) more than yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Effect of Lung (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Direct gram. Wasserman.

(Signed) Paul Padget, M. D.

11-15-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick, Md.

DATE OF BURIAL Nov. 17 19 3

20 UNDERTAKER M. R. Stetsincarton

ADDRESS Frederick

HARRISON JONES, M. D.
Registrar

ec. 8-16-29—L. F. S.—100 Bks.

E 62389

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62389

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 510 N. Chester ST., 7-9 WARD)

2—FULL NAME Josephine Sucha

(a) RESIDENCE NO. 510 N Chester ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: wml

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Sucha

DATE OF BIRTH (month, day, and year): May 14, 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63	64	5	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0-7

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Austria

10 NAME OF FATHER: Joseph Rikoa

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Sulavan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

Informant: Joseph Sucha

(Address) 510 N Chester St

5 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 14/30

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930 to Mar 14, 1930, that I last saw h[illegible] alive on Mar 14, 1930 and that death occurred on the date stated above, at 10:40 A m.

The CAUSE OF DEATH was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Dunka M. D.

1 19 30 (Address) 800 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Mar 17 19 30

20 UNDERTAKER: Frank Brocka on 1906

ADDRESS: Oakland

c.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62390 V 161-61 E. 62390

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2954 Clifton ave ST. 15-61 (WARD)

2-FULL NAME Baby Boy Akers

(a) RESIDENCE NO. 2954 Clifton Av. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 14th 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Phillip J Akers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

PARENTS

14 Informant Mrs Rose Smith

(Address) 2954 Clifton ave

15 Filed ..... 5 1930 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14th, 1930, to Nov. 14th, 1930, that I last saw her alive on ~~Dec~~ Nov 14th, 1930, and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) A M Byers, M. D.

, 19 (Address) 304 Eutaw Pl Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL NOV 19

20 UNDERTAKER Commissioner Health.

ADDRESS

UNIVERSITY OF MARYLAND

Dep. Wm. E. Woodall

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62391

E 62391

CERTIFICATE OF DEATH

100-001

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 1917 ST. (WARD)

2—FULL NAME Wilbur Jones Jr.

(a) RESIDENCE NO. 525 Vincent St. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) May 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: Wilbur Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Theresa Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant

(Address)

15 NOV 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-30

17 I HEREBY CERTIFY, That I attended deceased from 11-12, 1930, to 11-14, 1930.

that I last saw h[illegible] alive on 11-14, 1930

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Tetany

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. W. Peake, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: NOV 15 1930

20 UNDERTAKER: [illegible] Baltimore Health

ADDRESS

[illegible] E. WOODALL

c.—1-30—M. & T.—250 Bks.

E 62392 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62392

CERTIFICATE OF DEATH.

90

REGISTERED NO. 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. Sinai Hosp. St. (WARD)

2-FULL NAME Isidor Bachrach

(a) RESIDENCE NO. 7812 Norfolk Av. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

11 If married, widowed, or divorced HUSBAND of or) WIFE of Carrie Fuld Bachrach

DATE OF BIRTH (month, day, and year) Nov. 2, 1867

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	0	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Brager Eisenberg

BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nathan Bachrach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Adam Bachrach (Address) 3411 Greenmount Avenue

15 5 1930 19 CRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1930, to Nov. 14, 1930, that I last saw him alive on Nov. 14, 1930, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

Chronic myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 3 min.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Edmund Levin, M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Friendship Cem.

DATE OF BURIAL 11/16/1930

20 UNDERTAKER Hurd Sondheimer Son

ADDRESS 1902 Eutaw Place

c.—1-30—M. & T.—250 Bks.

62393 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 62393

99-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 4030 Lewiston Ave (STREET) 27-5 (WARD)

2-FULL NAME Mrs Susan Frances Hughes.

(a) RESIDENCE NO. 4030 Lewiston Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of .....

DATE OF BIRTH (month, day, and year) July 1. 48

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	4	13.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Jacob A Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan F. Rooky.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Blanche D. Shaw
(Address) 4030 Lewiston Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 14, 1930, that I last saw h-er alive on Nov 14, 1930, and that death occurred, on the date stated above, at 3 30 p m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) ✓ yrs. ✓ mos 10 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ✓ yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon M. D.

11/15, 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Nov 17 1930

20 UNDERTAKER George J. Smith

ADDRESS 1532 Fallsway

51930

30—M. & T.—100 B—50L

E 62394

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62394

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No. Balto City Hospital ST. 21-44 WARD)

REGISTERED NO. 188-101

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence A Martin

(a) RESIDENCE NO 2505 Ailsa ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Agatha Martin

6 DATE OF BIRTH (month, day, and year) Feb 23 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	22 21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steam R.R Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer) Penn. R.R. 0/3
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co

PARENTS

10 NAME OF FATHER Richard Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Susan Gist

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Agatha Martin

(Address) 2505 Ailsa ave

NOV 16 1930 HAROLD J. JONES, M.D. Registrar

Dat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed chest Abdomen
Steam R.R. accident
accidental

(duration) yrs. Instant mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bayview Freight Yds

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D. Coroner

11, 14, 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem DATE OF BURIAL 11-16 1930

20 UNDERTAKER J J Reed ADDRESS 2005 Eutaw

...—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62395

90 E 62395

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 219 E. Biddle ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kettie Rebecca Ditman

(a) RESIDENCE NO. 219 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 45 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of William C. Ditman

DATE OF BIRTH (month, day, and year) Feb. 22, 1865

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	8	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Harford County
(State or country) Maryland

10 NAME OF FATHER Jacob F. Barrow

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary V. Ensey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Miss Grace B. Ditman

(Address) 219 E. Biddle Street

Filed NOV 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1930, to Nov 15th, 1930,

that I last saw h... alive on Nov 14th, 1930

and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

hypostatic pneumonia

acute dilatation

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) arterio sclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? yes

What test confirmed diagnosis? sym + typical

(Signed) [illegible], M. D.

Nov 15th, 1930 (Address) 1308 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 11/17 1930

20 UNDERTAKER Henry U. Mears and Son

ADDRESS 825 N. Calvert

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62396 49 E 62396

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Caulins & Oliver ST. 9-18 WARD)

2-FULL NAME Michael J. Higgins

(a) RESIDENCE NO. 1805 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 7 mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Anna Bailey

DATE OF BIRTH (month, day, and year) --------

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	55	--	--	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Repairman

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City

(c) Name of employer Fire Department

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Anna Higgins 1805 Aisquith Street

15 Filed DEC 1 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 19.., to Nov 12, 19 30.

that I last saw him alive on Nov 12, 19 30

and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Glioma of Brain

over

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/30/30 & 11/4/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + pathological

(Signed) C. McKenna, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/17 19 30

ADDRESS 805 N. Calvert

20 UNDERTAKER Henry U. Pearce and Son

Rec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62397 113 E 62397

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1708 Lancaster ST., 2-4 WARD)

2—FULL NAME Raymond M. Coral

(a) RESIDENCE NO. 1708 Lancaster ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 1, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		3	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Raymond Coral

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Celestino Sierra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant Raymond Coral

(Address) 1708 Lancaster St

15 Filed NOV 1 1930 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930, to Nov 14, 1930, that I last saw h alive on Nov 14, 1930 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia - Influenza Collapse

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Heart failure & asthma (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jay D Rinehart, M. D.

, 19 (Address) 1625 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Nov. 16 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St & Broadway

ec.—1-30—M. & T.—250 Bks.

242626 E 62398 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62398

CERTIFICATE OF DEATH. X 51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST. 9-9 WARD)

2-FULL NAME William Schulz

(a) RESIDENCE NO. 39 Rhodes Ave ST., WARD Charleston W Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) June 13-1925

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	5	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER G. L. Schulz

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C.

12 MAIDEN NAME OF MOTHER Irene White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D.C.

14 Informant Parents (Address)

15 Filed ....., 19.... HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1930, to Nov 15, 1930, that I last saw him alive on Nov 15, 1930, and that death occurred, on the date stated above, at 4.50 p.m.

The CAUSE OF DEATH* was as follows:

Rheumatic Carditis

(duration) ....yrs. ✓ mos ....ds.

CONTRIBUTORY (Secondary) acidosis

(duration) ....yrs. ✓ mos. ....ds.

18 Where was disease contracted if not at place of death? Charlestown W. Va.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

11/16, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mortin W. Hysong Co

DATE OF BURIAL Washington D.C. 19

20 UNDERTAKER Washington D.C.

ADDRESS 11/16/30

6 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

62399 × 188-203 62399

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Agnes Hosp. (St., Ward) 25-12

2-FULL NAME James E. Euler

(a) RESIDENCE NO. 605 Washington Ave. St., Ward Balto Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 Yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A Eliz Euler

6 DATE OF BIRTH (month, day, and year) May-14-1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paper Box
(b) General nature of industry, business, or establishment in which employed (or employer) Mfgr
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Euler

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Foutz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant A. Elizabeth Euler
(Address) 605 Washington Ave

15 Filed ..... 19 ..... BENJAMIN JOHNS, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto in which he was a rider collided with another auto throwing him out

(a) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Old Frederick Rd Balto Co

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. J. Frame, M. D.

11-14, 1930 (Address) 2939 W. Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Nov 17 '30
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2678 Pa

Important: See instructions on reverse side.

NOV 16 1930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62400 — 129 E 62400

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 - W. Franklin St. 1876 WARD)

2-FULL NAME Mary M. Matthews

(a) RESIDENCE NO. 1203 - W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown.

6 DATE OF BIRTH (month, day, and year): 8-24-1842

7 AGE: Years 88; Months 2; Days 14; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): same. 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Stephen Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Louis Peters

(Address): 1203 W. Franklin

15 Filed 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-13- 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-20- , 1930 , to 11-13- , 1930 ,

that I last saw her alive on 11-12- , 1930

and that death occurred, on the date stated above, at 4 A. m

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Forgie, M. D.

11-14-, 1930 (Address) 601 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hunters Maryland — DATE OF BURIAL: 11-17 1930

20 UNDERTAKER: Wm Fitz H. Williams — ADDRESS: 322 N. Charles St.

30—M. & T.—100 B—50L

E 62401

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62401

CERTIFICATE OF DEATH

REGISTERED NO. 1-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Montague

(a) RESIDENCE NO 604 W. La Fayette ST., WARD 9-6

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	4			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Wm Montague

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Emma Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Ca.

14 Informant Wm Montague
(Address) 604 W La Fayette

15 [illegible] JAMES H. JONES, M. D.
Registrar

V 16 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12th 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ...(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ...(Inquest, autopsy or inquiry.) find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) ... Coroner, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount. N. C.

DATE OF BURIAL 11-15 19 30

20 UNDERTAKER David Carter

ADDRESS 9-6 Ca ave

...c.—1-30—M. & T.—250 Bks.

E 62402 ✓ E 62402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Bruce st. ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Effie Mathews

(a) RESIDENCE NO. 808 N. Bruce st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Negro	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Jos. Mathews

DATE OF BIRTH (month, day, and year) April 12 1907

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jos. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louisa Johnson

(Address) 808 N. Bruce st

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12th, 1930 to Nov. 15th, 1930.

that I last saw her alive on Nov. 14th. 1930

and that death occurred, on the date stated above, at 9;30 m.

The CAUSE OF DEATH* was as follows:

Acct. Miliary Tuberculosis

(duration) ... yrs. ... mos 10 ds. ?

CONTRIBUTORY (Secondary) Unknown (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 11-15-1930

UNDERTAKER Dennis Easton

ADDRESS 916 Park

16 1930

JONES, H.

rec.—1-30—M. & T.—250 Bks

E 62403 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 E 62403

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 14-20 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Smith

(a) RESIDENCE NO. 1817 Little Walsh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) March 24 ?

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	7	18	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Caroline Co. Va.

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rosa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of Address Balto. City Hosp.

15 Filed ..., 19... [illegible] JONES, M. D. Registrar

16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12-30

17 I HEREBY CERTIFY, That I attended deceased from 10-30-30, 19..., to 11-12-30, 19..., that I last saw him alive on 11-12-30, 19..., and that death occurred, on the date stated above, at 7:44 P m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta
with aortic insufficiency
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis, chronic
(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam, Wasserman

(Signed) Paul Padget, M. D.

11-13, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 11-15-1930

20 UNDERTAKER Dennis Estate ADDRESS 916 Druid

Mumaghans

...—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2404

CERTIFICATE OF DEATH.

Ht E 62104

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 918 Hollins St. 18-29 (WARD)

2-FULL NAME William Mumaghan

(a) RESIDENCE NO. 918 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Laura Mumaghan

7 DATE OF BIRTH (month, day, and year) May 1865

8 AGE — Years: 65 — Months: — — Days: 6 — If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Mumaghan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McArdle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Sally Mumaghan

(Address) 918 Hollins St

15 Filed NOV 16 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930. to Nov 14, 1930.

that I last saw h... alive on Nov. 13, 1930.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver

(duration) over 6 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) , M. D.

11/16, 1930 (Address) 1503 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 11/18/30

UNDERTAKER: Fullem & Sons

ADDRESS: Fayette

-30—M. & T.—100 B—50L

E 62405

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 62405

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 112 Colvin St. ST., 5-8 WARD)

2-FULL NAME Raymond Bennett.(C)

(a) RESIDENCE NO 112 Colvin St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St.Marys Co.Md.

PARENTS

10 NAME OF FATHER Stephen Bennett.(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) St.Marys Co.Md.

12 MAIDEN NAME OF MOTHER Ella Chase.(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St.Marys Co.Md.

14 Informant Mabel Nelsom.)C) sister.

(Address) 1745 Jefferson St.

15 Filed NOV 16 1930 C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D. Coroner

11/15/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ast-ury cemetery — DATE OF BURIAL Nov 17, 30

20 UNDERTAKER Edward Bryan — ADDRESS 1691 orleans st

ec.—1-30—M. & T.—250 Bks

E 62406

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 62406

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospital 8-16 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Pearl Anna Jones

(a) RESIDENCE NO. 1413 N. Rose ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced (HUSBAND of or) WIFE of -

DATE OF BIRTH (month, day, and year) Nov. 24, 1880

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0'10

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Plamer

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Gordon

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed DEC 16 1930 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-30

17 I HEREBY CERTIFY, That I attended deceased from 10-16-28, 19.. to 11-14-30, 19..

that I last saw her alive on 11-14-30, 19..

and that death occurred, on the date stated above, at 9:40 P m.

The CAUSE OF DEATH* was as follows:

Syphilis, Tertiary.

more than 2 yrs. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ulceration 2 Leg & Lymphangitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jas. Gilmour Jr., M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem Nov. 14 1930

DATE OF BURIAL

20 UNDERTAKER John C. Miller 2435 E Oliver

ADDRESS

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

62407 90 E 62407

CERTIFICATE OF DEATH

REGISTERED NO. 23-32

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1753 Hanover St. ST., WARD

2-FULL NAME Sarah Kerner.

(a) RESIDENCE NO 1753 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ---mos. ---ds. How long in U. S., if of foreign birth? 1 yrs. ---mos. ---ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If ~~MARRIED, WIDOWED, DIVORCED~~ of (or) WIFE of Morris Kerner.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Huna Flax.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Rose Sobelman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Dora Barnish. (daughter)

(Address) 1753 Hanover St.

15 Filed 11 1930 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 14, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) H. M. Leonard Coroner, M. D.

11/15/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. View Russdale

DATE OF BURIAL 11-17 1930

20 UNDERTAKER Pace Evans, 1439 E. Dale St

ADDRESS

Dec.—1-30—M. & T.—250 Bks.

E 62408

HEALTH DEPARTMENT—CITY OF BALTIMORE

12 E 62408

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 13-59 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Sachs

(a) RESIDENCE NO. 2316 Bryant Ave ST., WARD 15. 310.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6a If married, widowed, or divorced (HUSBAND of or) WIFE of Hannah Sachs

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) I. Lewis 1439 Eutaw St

15 FILED 1930 HARRISON JONES, M. D. Registrar

1 Filed ..... 19.....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15/30.

17 I HEREBY CERTIFY, That I attended deceased from 10/6, 1930, to 11/15, 1930, that I last saw him alive on 11/15/30, 19....., and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Empyema of Gall Bladder

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Cardiac failure c pulmonary (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 11/14/30.

Was there an autopsy? Yes. What test confirmed diagnosis? (partial) Laparotomy Physical findings & Autopsy

(Signed) Max Cohen, M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakeview Funeral Home

DATE OF BURIAL 11-11-1930

ADDRESS

20 UNDERTAKER Jacob Lewis 1439 Eutaw St

M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62409 × 40 E 62409

REGISTERED NO. .....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

TY OF BALTIMORE: (No. City Hospital ST., 70-27 WARD)

2-FULL NAME Phillip Bernstein

(a) RESIDENCE NO. 1916 E. Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ritta Bernstein

DATE OF BIRTH (month, day, and year) -----

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown Bernstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Benj. Cohen
(Address) 1916 E. Fayette St.,

Filed ... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11- 14 - 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos ... ds.

CONTRIBUTORY (Secondary) Decompensation

(duration) ... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1916 E Fayette

Did an operation precede death? ... Date of .....

Was there an autopsy? ...

What test confirmed diagnosis? Clinical

(Signed) James M Benton, M. D. Coroner

(Address) 7006 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Sinai Hebrew

DATE OF BURIAL 11/16 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore

NAMSON JONES, M.D.

...—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62410 E 62410

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3813 Walnut Av ST. 27 Prob WARD)

2-FULL NAME Delia Duffy

(a) RESIDENCE NO. 3813 Walnut ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Duffy

7 DATE OF BIRTH (month, day, and year) June 10 1857

8 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Cuff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Golden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Frank L. Duffy (Address) 3813 Walnut Ave.

15 Filed NOV 1930 19 ... Registrar Ralph Jones, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1929, to Nov 14, 1930, that I last saw h... alive on Nov 14, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis (chronic)

(duration) 1 yrs. 1 mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs + Symptoms

(Signed) Edw H Benson, M. D.

11/15, 19 30 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem...

DATE OF BURIAL 11/18/30.

ADDRESS

20 UNDERTAKER Frederick Leasman Sons 2401 Eden St.

Dec.—1-30—M. & T.—250 Bks.

E 62411

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62411

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH Provident Hosp. ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division

2-FULL NAME William Crump

(a) RESIDENCE NO. Cardiff Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced (w) HUSBAND of (w) WIFE of Jessie D. Crump

7 DATE OF BIRTH (month, day, and year) ? 1877

8 AGE 53 Years 53 | Months | Days | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jessie Crump

(Address) Dela, Ga.

C. H. Bacon JONES, M.D. Registrar

Filed 1930, 19 per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14/30

17 I HEREBY CERTIFY, That I attended deceased from 10/14/30, 19....., to 11/14, 1930,

that I last saw him alive on 11/14, 1930,

and that death occurred, on the date stated above, at 1 1/2 a.m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of the Head of the pancreas (duration) Unknown

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Dr. George McDonald, M. D.

11/14, 1930 (Address) 900 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dela, Ga.

DATE OF BURIAL 11/17/1930

20 UNDERTAKER Wm. Geo. H. Holland

ADDRESS 1631 Druid

spec.—1-30—M. & T.—250 Bks

E 62412

E62412

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 S Collington ave ST. 13 WARD)

2-FULL NAME Mary A. McDonald

(a) RESIDENCE NO. 108 S Collington ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX F. | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1852

7 AGE — Years 78 | Months 5 | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Owen McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Eliz Kerr (Address) 3108 S Collington ave

15 Filed NOV 18 1930 C. HALSTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1930, to Nov 14, 1930, that I last saw h[illegible] alive on Nov 14, 1930, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) ..... yrs. ..... mos. 3 da.

CONTRIBUTORY (Secondary) Chronic nephritis.

(duration) 6 yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical & urine test

(Signed) Harry A McCleary M. D.

11-15, 1930 (Address) 37 W. Preston Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cathedral Ben | DATE OF BURIAL 11/17/1930

20 UNDERTAKER J. A. Moran | ADDRESS E Baltimore

1-30—M. & T.—100 B—50L

E 62413

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E 62413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1310 N. Stockton ST. 15-23 WARD)

2-FULL NAME Estella Watts

(a) RESIDENCE NO 1310 N. Stockton ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Hilary Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mattie Watts

(Address) 1310 Stockton

15 Filed 1-7-1930, 192 HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7-30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) Coroner, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Nov 17 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St.

ec.—1-30—M. & T.—250 Bks.

E62414

E 62414 HEALTH DEPARTMENT—CITY OF BALTIMORE

E62414

E 62414

CERTIFICATE OF DEATH.

REGISTERED NO. 21-001

1-PLACE OF DEATH Provident Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division St. 1624 WARD)

2-FULL NAME William D. Schuyler

(a) RESIDENCE NO. 1116 Madison Ave ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Georgine Schuyler

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah Schuyler (Address) 1116 Madison Ave

15 Filed NOV 8 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1930, to Nov. 14, 1930, that I last saw him alive on Nov. 14, 1930, and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Haemorrhagic Lepto-Meningitis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical + Autopsy

(Signed) Dr. George McDonald M. D.

11/14, 1930 (Address) 1000 Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lowes Cem.

DATE OF BURIAL 11/16, 1930

ADDRESS

20 UNDERTAKER Samuel Newsley

ADDRESS 1112 Biddle

pec.—1-30—M. & T.—250 Bks.

E 62415

E 62415

E 62415

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST. 15-63 WARD)

2-FULL NAME Margaret Wagner.

(a) RESIDENCE NO. 3800 Garrison Boulevard WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 22 1872

7 AGE: Years 57 | Months 10 | Days 24 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Clay Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sarah Small

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Sister - Mary Wagner

(Address) 3800 Garrison Baltimore Md

15 Filed 11-17-1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16-30

17 I HEREBY CERTIFY, That I attended deceased from 9-25-30, 19..., to 11-16-30, 19...,

that I last saw her alive on 11-16-30, 19...,

and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Caecum - - -

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Post-operative Cardiac Embolus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Intra-abdominal metastasis 10-6-30

Did an operation precede death? Yes Date of Removal Tumor 11-14-30

Was there an autopsy? Yes

What test confirmed diagnosis? Superficial & clin.

(Signed) Hilmar S. Anderson, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL Nov 18 1930

20 UNDERTAKER Robert S Settle ADDRESS 2700 Edmondson Ave

pec.—1-30—M. & T.—250 Bks.

E. 62416.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62416

CERTIFICATE OF DEATH.

129

E 62416

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Brandt-

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Brandt-

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mary Myers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address)

15 Filed 1 7 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/14, 1930, to 11/17, 1930, that I last saw h alive on 11/16, 1930, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Oedema (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wolff M. D.

11/17 1930 (Address) 1216 E Caloverte

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Nov. 18 1930

20 UNDERTAKER Ruth Mudfield

ADDRESS 914 Gruman Ave

Dec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62417

CERTIFICATE OF DEATH

75-001

E 62417

REGISTERED NO. 13-52

1—PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 40th & Clewiston Rd ST., WARD)

2—FULL NAME Louisa Eugene F. Cordell

(a) RESIDENCE NO. Home for Incurables ST.

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Dr Eugene F. Cordell

7 DATE OF BIRTH (month, day, and year) Mar. 15, 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in whirh employed (or employer) —

(r) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Richmond, Va.

PARENTS

10 NAME OF FATHER Dr. James B. Southall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Isle of Wight, Va —

12 MAIDEN NAME OF MOTHER Martha F. Lazenby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond, Virginia

14 Informant Hospital Records —

(Address) 40th & Clewiston Rd.

15 Filed NOV 17 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1930, to Nov 15, 1930, that I last saw h a alive on Nov 14, 1930. and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Senility, Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? none

(Signed) L. L. Leitch, M. D.

11/15, 1930 (Address) Keswick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlestown W. Va

DATE OF BURIAL Nov 18 1930

20 UNDERTAKER Henry W. Jenkins & Sons Co

ADDRESS Edward Hall Ave

pec.—1-30—M. & T.—250 Bks

Parks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62418

CERTIFICATE OF DEATH.

113

E 62418

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Greene ST. 7-10 WARD)

2-FULL NAME Helen Parks

(a) RESIDENCE NO. 540 N. Eugene ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 13. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wesley Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Agatha Dehaven

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Wesley Parks
(Address) 540 N. Eugene Ave

15 Filed NOV 17 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1930, to Nov. 15, 1930,

that I last saw her alive on Nov. 15, 1930,

and that death occurred, on the date stated above, at 4:30a.m.

The CAUSE OF DEATH* was as follows:

Uremia - Colitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G. Lyon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov. 17 1930

20 UNDERTAKER William G. Schaeffer 1816 E. Monument

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

14-001

E 62419

CERTIFICATE OF DEATH

E 62419

REGISTERED NO. E 62419

1—PLACE OF DEATH 937 Lexington St

CITY OF BALTIMORE: (No. Baltimore ST. 2331 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Smith

(a) RESIDENCE NO. 937 Lexington St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Richard S Butler (Address) 937 Lexington St

15 Filed Nov 17, 1930 C. HAMPSON JONES, M. D. Registrar

N 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 30

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 13, 1930, that I last saw him alive on Nov 12, 1930 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) — yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Thomas, M. D.

Nov 17, 1930 (Address) 711 S. Mary Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct — DATE OF BURIAL Nov 17 1930

20 UNDERTAKER C. H. Brown & Son — ADDRESS 1091 W. Fayette

1-30—M. & T.—100 B—50L

E 62420

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62420

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3201 Garrison (St.) 26-9 (WARD)

2-FULL NAME Isaac Tucker

(a) RESIDENCE NO. 1716 E Balto ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Celia

6 DATE OF BIRTH (month, day, and year): Jan 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Grocery Store
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Solomon Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Celia Strestman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Samuel Tucker

(Address) 2703 Hilldale Rd

Filed NOV 17 1930 1902 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 16th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) ..... Coroner, M. D.

....., 19 (Address) Brown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arlington Cemetery

DATE OF BURIAL: 11-17-1930

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 E Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 62421

HEALTH DEPARTMENT—CITY OF BALTIMORE

58 1001

E 62421

CERTIFICATE OF DEATH

REGISTERED NO. 1359

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 737 Newington Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Galt

(a) RESIDENCE NO. 737 Newington Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: Robert G. Galt

7 DATE OF BIRTH (month, day, and year): Dec. 24, 1853

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Joseph Hampson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Maryland

12 MAIDEN NAME OF MOTHER: Margaret A.L. Erbly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mr. Edward S. Hampson

(Address) 2702 St. Paul St.

15 Filed 17 1930 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 21st 1930, to Nov. 15th 1930, that I last saw her alive on Nov. 14th 1930, and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ~

(duration) ~ yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Eugene Douglas —, M. D.

11/15, 1930 (Address) 3043 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Nov. 17 1930

20 UNDERTAKER: Harold Cook

ADDRESS: 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 62423

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62423

CERTIFICATE OF DEATH

57

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 E. Lanvale ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose Watson Frey

(a) RESIDENCE NO. 1009 E. Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Frey

7 DATE OF BIRTH (month, day, and year) May 16, 1855

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	5	24 30	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Actress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Harford County Maryland

PARENTS

11 NAME OF FATHER John Watts

12 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County Maryland

13 MAIDEN NAME OF MOTHER Louisa Prichard

14 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Clara M. Leight

(Address) 1009 E. Lanvale St.

15 Filed NOV 17 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1928 to Nov 11, 1930

that I last saw her alive on Nov 11, 1930

and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sugar test

(Signed) J. H. Wade, M. D.

10/16, 1930 (Address) 118 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov. 17 1930

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Bks. Laura E Smallwood.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 62423

CERTIFICATE OF DEATH.

185

E 62423

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 15-61 WARD)

2-FULL NAME ~~Mrs John~~ Smallwood (Laura Elizabeth)

(a) RESIDENCE NO. 3412 Powhatan Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Smallwood.

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert H. Horner

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Caroline Smith.

13 BIRTHPLACE OF MOTHER (city or town) Cockeysville (State or country) Md.

14 Informant Carrie Henderson (Address)

15 Filed NOV 17 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1930, to Nov. 15, 1930, that I last saw h.. alive on Nov. 15, 1930, and that death occurred, on the date stated above, at 9 25 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Intoxication of acute

(Coroner J. J. Kearney J)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Fracture of left femur.

(duration) yrs. 1 mos. 8 ds. gd

18 Where was disease contracted, if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin H. Mortimer Jr. M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL Nov 18 1930

UNDERTAKER Wm. T. Tucker Sons

ADDRESS North & Pa

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62424 E 62424

CERTIFICATE OF DEATH.

62424

1-PLACE OF DEATH St. Agnes Hospital REGISTERED NO.

CITY OF BALTIMORE. (No. Wilkens & Caton Ave ST. 27-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Jan Forester

(a) RESIDENCE NO. Green Spring Mayfrost ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3. 1867.

7 AGE: 63 Years; Months 7; Days 12; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr G. Freundlich.

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Ernst Plum Von Forester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Michigan

12 MAIDEN NAME OF MOTHER Emma Foucher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant (Address) Mrs S. Meza - daughter.

15 Filed NOV 17 1930 16 C. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1930, to Nov. 15, 1930.

that I last saw h alive on Nov. 15, 1930,

and that death occurred, on the date stated above, at 12 15 0 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary & metastases

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Laparotomy Date of 10/17/30.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt Dewar, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Charles Pikesville Md. DATE OF BURIAL: Nov. 18, 1930.

20 UNDERTAKER: Martin Fahey & Sons ADDRESS: 1827 W. North ave

TION is very important See instructions on back of Certificate

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92

E 62425 REGISTERED NO. E 62425

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2507 Ailsa Ave. ST. 27-43 WARD)

2—FULL NAME Perry Sinclair

(a) RESIDENCE NO. 2507 Ailsa Ave. ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha A. E. Sinclair

6 DATE OF BIRTH (month, day, and year) Apr. 27, 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Perry Sinslair

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Sherwood

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Miss Mildred Sinclair
(Address) 2507 Ailsa Ave.

15 Filed 17-1930, 19 HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/17/30.

17 I HEREBY CERTIFY, That I attended deceased from Aug, 19 30, to 11/17, 19..., that I last saw h alive on 11/17, 19 30 and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hanson Jones M. D.

19 (Address) 503 Kenyon Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Nov. 19 1930

DATE OF BURIAL

ADDRESS

20 UNDERTAKER Wm. C. Black 922 W. Broadway

Form 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 62426 — REGISTERED NO. E 62426

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1507 N. Collington Ave. WARD 8/16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Gundlach.

(a) RESIDENCE NO. 1507 N Collington Ave WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 25, 570

7 AGE: Years 60 Months 8 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (City or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John F. Gundlach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germ

12 MAIDEN NAME OF MOTHER: Magdalena Goetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germ

14 Informant (Address): Miss Minnie Gundlach 1507 Collington Ave.

15 [illegible] 1930

19 HAMILTON JONES, M. D. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Novem Fri 14 1930

17 I HEREBY CERTIFY, That I attended deceased from September 1 1930, to November 14. 1930.

that I last saw him alive on November 13. 1930.

and that death occurred, on the date stated above, at 8 00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterial Hypertension (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy and Uraemia (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert E. Dowling, M. D.

11/14 1930 (Address) 2005 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Nov 17 1930

20 UNDERTAKER: E. Schloman & Son ADDRESS: 1039 Lanvale

FION is very important. See INSTRUCTIONS on

Spec.—1-30—M. & T.—250 Blks.

24255?

E 62427

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 E 62427

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 23-31 WARD)

2-FULL NAME Henry W. Dorsey

(a) RESIDENCE NO. 2 So W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	married (sep)

5a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer, 40

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Betty Ware

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 17 1930 Received C. HINSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13-30

17 I HEREBY CERTIFY, That I attended deceased from 11-11-, 1930, to 11-13-, 1930, that I last saw h alive on 11-13-, 1930, and that death occurred, on the date stated above, at 1200 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Bronco-pneumonia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Upshur Dr M. D.

11/15, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Glen

DATE OF BURIAL Nov 17 1930

20 UNDERTAKER Sam'l P. Chase & Son

ADDRESS 1405 W Fayette

NOV 17 1930

Spec. 1-30 M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62428

CERTIFICATE OF DEATH.

74-001

E 62428

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Crisp St ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Murray

(a) RESIDENCE NO. 707 Crisp St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Murray nee Parks

6 DATE OF BIRTH (month, day, and year) Feb. 14. 1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country)

PARENTS

10 NAME OF FATHER Wm. H. H. Murray

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Co.

12 MAIDEN NAME OF MOTHER Barbara E. Nash

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Co Md

14 Informant Mrs Josephine Murray
(Address) 707 Crisp st

15 Filed NOV 17 1930 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930, to Nov 14, 1930,

that I last saw him alive on Nov 14, 1930,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

11/17, 1930 (Address) 733 Airyiew St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dear Park M. E. Cemetery

DATE OF BURIAL Nov. 18, 1930

20 UNDERTAKER Edmund W. Conklin

ADDRESS 824 E. Eager St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62429

CERTIFICATE OF DEATH

E 62429

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

City of Baltimore: (No. South Balto. General Hospital St., 24-33 Ward)

2 FULL NAME William P. Todd

(a) RESIDENCE NO. Princess Anne Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Mitchell

6 DATE OF BIRTH (month, day, and year) Aug. 15. 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Penna.
(State or country)

PARENTS

10 NAME OF FATHER Wm. A. Todd

11 BIRTHPLACE OF FATHER (city or town) Penna.
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Archbold

13 BIRTHPLACE OF MOTHER (city or town) Penna.
(State or country)

14 Informant Julian A. Todd
(Address) Wilmington Del.

Filed NOV 17 1930 HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & knocked down by a moving truck while resting (his car having disabled)
(duration) Instant Skull
CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Crain Highway

Did an operation precede death? No Date of

Was there an autopsy? (Cranial) only

What test confirmed diagnosis? clin & P. M. findings

(Signed) H. Frame M. D. M. D.

Nov. 16. 1930 (Address) 2939 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester Pa.

DATE OF BURIAL Nov 17. 1930

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Eitaw Place

John O. Mitchell

IMPORTANT. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 62430 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 62430

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Lenbrook Memorial Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1000 Eaton (St.) 11-74 (WARD)

2-FULL NAME Josephine Whalen

(a) RESIDENCE NO. 1321 Eutaw Place STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Servant 70

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Lenbrook Memorial Hosp 1000 Eaton Ave

15 Filed NOV 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 16, 1930, that I last saw h[illegible] alive on Nov 15, 1930, and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis duration (?) yrs. mos. ds.

Enterospelerosis with Hypostasis

CONTRIBUTORY (Secondary) Myocardial failure duration yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Palmer S. Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine Crest Cemetery	Nov 19 1930
UNDERTAKER John A. Mitchell Sons	ADDRESS 1911 Eutaw

Spec.—1-30—M. & T.—250 Bks.

E 62431

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62431

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3610 Roberts Place ST. 26-37 WARD)

2. FULL NAME Carrie Schissler

(a) RESIDENCE NO. 3610 Roberts Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Joseph Schissler

6 DATE OF BIRTH (month, day, and year) May 29-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Thomas
(Address) 3610 Roberts Place

15 Filed V 17 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 15 1930
that I last saw her alive on Nov 15 1930
and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

Arteriosclerosis (duration) ... yrs. 15 mos ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? ---

(Signed) J. Noah Taylor M.D.

Address 1117 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Nov 18, 1930

20 UNDERTAKER John Ulmer Et

ADDRESS 2008 Eutaw

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62432

E 62432

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 407 N. Caroline ST. 6-9 WARD)

2-FULL NAME Archibald S. Carmack Sr

(a) RESIDENCE NO. 407 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	W.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Laura Carmack

6 DATE OF BIRTH (month, day, and year) Sept. 15. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lewis Carmack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Vernon Roberts

(Address) 1864 Seventh ave. N.Y.

15 Filed 1 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8 1930 to Nov 15 1930.

that I last saw him alive on Nov 15 1930

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chr Interstial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Senile Change

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Coleen B. le Compte M. D.

19 (Address) 1113 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Del. St. Thomas Cem. Glasgow

DATE OF BURIAL Nov 18 1930

20 UNDERTAKER Clair N. Johnson 416 N.

ADDRESS Caroline St.

TION is very important

Spec.—2-29-28—L. F. S.—500 Bks.

E 62433

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62433

CERTIFICATE OF DEATH

74-001

REGISTERED NO. 37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 S. Grundy ST. OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia Thierl

(a) RESIDENCE NO. 632 S. Grundy ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Thierl

6 DATE OF BIRTH (month, day, and year) Jan. 7 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Betz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosina Stoeber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Thierl (Husband)

(Address) 632 S. Grundy St.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from October 29, 1930, to Nov 14th, 1930, that I last saw her alive on Nov. 14th, 1930 and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage (Rt),

b Hypertension

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical findings.

(Signed) Michael D. Abrahms, M. D.

Nov 15, 1930 (Address) 2360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL Nov. 18th 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62434

CERTIFICATE OF DEATH

E 62434

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Bon Secours Hosp St., Ward)

2-FULL NAME Mrs Helen M Smith

(a) RESIDENCE NO. 1502 Eutaw Place St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Wh	Married

5a If married, widnwed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16 1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature nf industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N Y
(State or country)

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) New York
(State or country)

12 MAIDEN NAME OF MOTHER Mary Dolan

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant Leslie F Smith
(Address) 1502 Eutaw Pl

15 Filed NOV 17 1930 By HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described abnve, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Ruptured Stomache and Cerebral Hemorrhage following delivery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operatinn precede death? Date of

Was there an autopsy?

What test cnnfirmed diagnosis?

(Signed) Chas H Brooke, M. D.

Nov 17, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York NY	11/1930
20 UNDERTAKER Joseph Finley Sulton Leyton	ADDRESS

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62435

E 62435

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3330 St Ambrose Ave ST. 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MARY Eliza Dorsett

(a) RESIDENCE NO. 3330 St Ambrose Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Nov 19. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Widow

(b) General nature of industry, business, or establishment in which employed (or employer) Widow

(c) Name of employer None

9 BIRTHPLACE (city or town) South River, Anne Arundel Co

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas H. Collison

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country) Anne Arundel Co

12 MAIDEN NAME OF MOTHER Mary E. Collinson

12 BIRTHPLACE OF MOTHER (city or town) Friendship, Md

(State or country) Calvert Co.

14 Informant Margaret J. Whitington

(Address) Dunkirk, Md.

15 Filed 19 HAMPSON JONES, M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-30

17 I HEREBY CERTIFY, That I attended deceased from 11/6/30, 19..., to 11/15/30, 19...,

that I last saw h ev alive on 11/15/30, 19...

and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

Chronic Myocarditis - duration - 1 yr.

Angina pectoris - 1 mo

Coronary Thrombosis - 8 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism - Rt hemiplegia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Effects

(Signed) Meyer Miller, M. D.

, 19 (Address) 3649 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friendship AAC. Md

DATE OF BURIAL Nov. 18 1930.

20 UNDERTAKER R J Wood

ADDRESS Friendship Md

R J Wood

GILLIAON

Spec.—1-30—M. & T.—250 Bks

E 62436 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62436

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital ST. 11-7 (WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Fr. Phillip Finnegan.

(a) RESIDENCE NO. Loyola High School WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	single.

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Catholic Priest.

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) New York. (State or country)

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Rev. J. C. Wheeler S.J. (Address) Calvert & Madison Sts.

15 11-16-30, 19 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16/30.

17 I HEREBY CERTIFY, That I attended deceased from 11/12, 1930, to 11/16, 1930.

that I last saw him alive on 11/16, 1930

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

3 hrs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 11/12/30

Was there an autopsy? no.

What test confirmed diagnosis? none.

(Signed) J. J. McCandless, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodstock, Md.

DATE OF BURIAL 1930

20 UNDERTAKER Henry H. Mears & Son ADDRESS 835 N. Calvert

17 11-30

Spec.—1-30—M. & T.—250 Bks.

E 62437 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62437

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. North Broadway ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Banks, Virgie

(a) RESIDENCE NO. 503 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D.C. (State or country)

PARENTS

10 NAME OF FATHER Augustus C. Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Hewett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Swift, Miss Grace (Address) 803 N Calvert

15 11 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15th, 1930.

17 I HEREBY CERTIFY, That I attended deceased from November 11, 1930 to November 15, 1930, that I last saw her alive on November 15th, 1930, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncito-Pneumonia (confluent)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray, Sputum examination

(Signed) J. Frank Hewitt, M. D.

11/13, 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 11/18/1930

20 UNDERTAKER Henry U. Mears and Son

ADDRESS 805 N. Calvert

Spec.—1-30—M. & T.—250 Bks.

E 62438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62438

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO.) 3125 ST. Pelham Ave WARD 40

2-FULL NAME Robert E. Schuler

(a) RESIDENCE NO. 3125 Pelham Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Elizabeth J Schuler

6 DATE OF BIRTH (month, day, and year) Aug 10-1875

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Louis Schuler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Dorothea Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John Schuler
(Address) 3125 Pelham Ave

Registrar

17 1930 ....., 19 .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/14, 1930, to 11/14, 1930,

that I last saw him alive on 11/14, 1930,

and that death occurred, on the date stated above, at 10.25 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs.? mos ds.

CONTRIBUTORY (Secondary) Cardio-respiratory collapse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray de

(Signed) Thos. E. Stacy, Jr. M. D.

, 19 (Address) 3825 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery-Nov 18 1930

DATE OF BURIAL

20 UNDERTAKER: Jos J Stevenson

ADDRESS 156 Eutaw Ave

Spec.—1-30—M. & T.—250 Bks.

E 62439 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62439

CERTIFICATE OF DEATH

100-001

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. Baltimore ST. 96-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Riley

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records City Hosp. (Address) Balto City Hospitals

15 Filed 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13-30

17 I HEREBY CERTIFY, That I attended deceased from 7-9-, 1921, to 11-13, 1930, that I last saw h[illegible] alive on 11-13, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Psychosis - Mental Deficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. F. R. Smith, M. D.

11/14 1930 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS NOV 17 1930

For Wm. B. Wood

UNIVERSITY OF MARYLAND

Spec.—1-30—M. & T.—250 Bks

62440 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62440

CERTIFICATE OF DEATH. 90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 16-37 ST. WARD)

2-FULL NAME Ida Coulas

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 1930 SAMPSON JONES, M. D. Registrar

71932

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-30

17 I HEREBY CERTIFY, That I attended deceased from 5-31-05, 19, to 11-15-30, 19, that I last saw her alive on 11-15-30, 19, and that death occurred, on the date stated above, at 1:55 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease, arteriosclerotic

(duration) unknown. yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, general. (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Almshouse - City Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Fidgett. M. D.

11-17, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Nov 19 1930

20 UNDERTAKER Charles H. Evans & Son

ADDRESS 1 W. Mt. Royal Ave Baltimore

Spec.—1-30—M. & T.—250 Blks.

E 62441

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62441

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Clinton St. 26-37 WARD)

2-FULL NAME Emma J Sollers

(a) RESIDENCE NO. 1402 J Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of James E Sollers

6 DATE OF BIRTH (month, day, and year) Mar 2-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo Reisinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Hannah York

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Nellie Keeney

(Address) 1402 Clinton

15 11 1930 . 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 12th 1929 to Nov 15- 1930

that I last saw her alive on Nov 15-30 8 A.M.

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J O Emmann M. D.

11/17/30 (Address) 2913 6 Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Nov 18, 1930

20 UNDERTAKER John Merrick

ADDRESS 2108 Arbutus

FROM A VERY IMPORTANT

Spec.—1-30—M. & T.—250 Bks

VANDERVEER V.

E 62442 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62442

CERTIFICATE OF DEATH.

REGISTERED NO. 74-00N

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No.) ST. 27-26 WARD

2-FULL NAME Charles Vanderyeey.

(a) RESIDENCE NO. 3820 Lewin Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Alice Vandeveer.

6 DATE OF BIRTH (month, day, and year) March 23, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown Lexington Building.

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER John H. Vandeveer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey.

12 MAIDEN NAME OF MOTHER Agnes Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey.

14 Informant (Address) Friend, BALTIMORE CITY HOSPITALS

15 Filed 17 1930, 19 MARION JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1930, to Nov. 15, 1930.

that I last saw h alive on Nov. 15, 1930.

and that death occurred, on the date stated above, at 12:40 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis, cerebral.

Yr. Middle cerebral artery.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, cerebral (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett. M. D.

11-16, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Va.

DATE OF BURIAL Nov. 17 1930.

ADDRESS

20 UNDERTAKER Horace F. Burgee 633 Fulton Ave.

E 62443 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62443

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3606 N. Rogers Ave (St.) 27-55 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. James Frank Morrison

(Residence in Baltimore: No. 3606 N Rogers ave St.; 4 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Marr

6-DATE OF BIRTH. January 28 1900
(Month) (Day) (Year)

7-AGE. 30 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Helper
(b) General nature of industry, business, or establishment in which employed (or employer) Ins Secretary Co

9-BIRTHPLACE, (State or Country). Mobile Ala

PARENTS

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin F Fisher

(Address) 3606 Rogers ave

15-

Filed ..... 192 ..... Registrar.

171930

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 16 1930
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(Duration) ..... yrs. Several days ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F E Lusk M. D.
(Coroner)

Nov 17 192 (Address) Boring

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mobile Ala DATE OF BURIAL. Nov. 17 1930

20-UNDERTAKER. Wm J Luckie Sons ADDRESS N. 4 Pa

is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 62144

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62144

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Marlborough apt. (ST.) 14 (WARD) 20

2-FULL NAME Katherine Metzel

(a) RESIDENCE NO. Marlborough Apts. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Metzel

6 DATE OF BIRTH (month, day, and year) Jan 29 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Franz Leutner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Aggus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Metzel (Address) Marlborough Apts

15 Filed 11 7 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1930, to Nov 16, 1930,

that I last saw her alive on Nov 16, 1930,

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

arteris-sclerosis

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of /

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Leutner, M. D.

11-16 1930 (Address) Temple Gardens Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL 11/18/1930

20 UNDERTAKER David Sondheim & Son

ADDRESS 1903 Eutaw Place

TION is very important. See instructions on

Spec.—1-30—M. & T.—250 Bks

E 62445 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62445

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 N. Ellwood Ave 6-11 ST. WARD)

2-FULL NAME George W. Both

(a) RESIDENCE NO. 137 N. Ellwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Adonna Both

6 DATE OF BIRTH (month, day, and year): Sept 4 1876

7 AGE: Years 54; Months 2; Days 10; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chief

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliz. Schuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Margaret A. Both 137 N. Ellwood Ave

15 Filed NOV 17 1930, 19 HANSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1930, to Nov 14, 1930,

that I last saw h[illegible] alive on Nov 14, 1930,

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. L. Mazer, M. D.

11/17, 1930 (Address) 612 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 11/18/1930

20 UNDERTAKER: J. G. Moran

ADDRESS: E Balto St.

Spec.—1-30—M. & T.—250 Blks

E 62446

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62446

CERTIFICATE OF DEATH.

REGISTERED NO. 74007

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST. 26-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Fleischman

(a) RESIDENCE NO. 417 S. East Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Laura

6 DATE OF BIRTH (month, day, and year) Nov. 10. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work out of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Philip Fleischman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hosp.

15 11 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-30

17 I HEREBY CERTIFY, That I attended deceased from 11-11-30, 19..., to 11-17-30, 19...,

that I last saw him alive on 11-17-30, 19...,

and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Thrombosis, cerebral;

Ht. arteriorcerebral artery.

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

Cerebral (duration) more than 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

11-17-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int. Laurel Cem

DATE OF BURIAL 11/20, 1930

20 UNDERTAKER J. J. Moran

ADDRESS 500 E. Baltimore

TION is very important. See instruction on back

Spec.—1-30—M. & T.—250 Bks

2 E Preston

E 62447

HEALTH DEPARTMENT—CITY OF BALTIMORE E 62447

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 243 S Bouldin ST. 76-37 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T Byrne

(a) RESIDENCE NO. 243 S Bouldin ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Patrick Byrne

6 DATE OF BIRTH (month, day, and year) March 17 1870

7 AGE Years 60 Months Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Robt. W. Gannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patk. Byrne (Address) 243 S Bouldin

15 Filed NOV 17 1930 19 HAMPSON JONES, K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to Nov 14, 1930, that I last saw her alive on Nov 14, 1930, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Urinalysis

(Signed) John E Purnell, M. D.

(Address) 76 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

20 UNDERTAKER J. A. Moran

DATE OF BURIAL 11/18 1930

ADDRESS 300 E Baltimore

TION is very important. See instructions on back

Spec.—1-30—M. & T.—250 Bks

Dr Tod 4700 Eastern Ave Wolf 4563

E 62448 · HEALTH DEPARTMENT—CITY OF BALTIMORE · E 62448

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 45 S. Kresson St. 16-37 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia R. Bell

(a) RESIDENCE NO. 45 S. Kresson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND OF~~ (or) WIFE of Leonard T. Bell

6 DATE OF BIRTH (month, day, and year) Oct 3rd 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of Industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ? Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ruth Katz (Address) 5407 York Rd

15 Filed NOV 17 1930 19 Registrar HARFORD JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 14th, 1930, to Nov 16th, 1930; that I last saw her alive on Nov 16th, 1930; and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetary

DATE OF BURIAL 11/19/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul st

TION is very important. See that the items on the

Spec.—1-10 21—M&T—1500 Blks.

E 62449

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62449

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (NO. 16-6 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eda Jackson.

(a) RESIDENCE NO. 2531 Armah Ave ST.: WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. J. Scott Jackson

6 DATE OF BIRTH (month, day, and year): Oct 31st 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	60	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John S. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant: J. Scott Jackson

(Address): 2531 Armah Ave

15 [illegible] 17 1930 .19 Filed [illegible] HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15th 1930

17

I HEREBY CERTIFY, That I attended deceased from 10 19 30 .19 to 11-15-30 .19,

that I last saw h&r alive on 11-15-30 .19,

and that death occurred, on the date stated above, at 10 20 P m.

The CAUSE OF DEATH* was as follows:

Cholecystatitis

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary): Pyelonephritis - Uremia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10 25 30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Hjalmar S. Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 11/18/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 62450

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62450

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3105 Guilford ave ST. 17-50 (WARD)

2-FULL NAME Mary Anna Marsden

(a) RESIDENCE NO. 3105 Guilford ave ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred all life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced (or) WIFE of Frank D Marsden

6 DATE OF BIRTH (month, day, and year) Aug 13-1853

7 AGE: Years 77; Months ~~Aug~~ 3; Days ~~13~~ 02

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Patrick Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Lillian Turner. (Address) 3105 Guilford ave

15 Filed 11 17 1930 C. HAMPSON JONES, Registrar. By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1927 to Nov. 15 1930, that I last saw her alive on Nov. 14 1930, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH was as follows:

Chron Interstitial Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hess MD, M. D.

11-15. 1930 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 11/18/1930

20 UNDERTAKER: Wm Cook 1217 St Paul St — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62451

62451

49

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 10-14 ST. (or WARD)

2-FULL NAME William Rust

(a) RESIDENCE NO. 1040 Somerset St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Edith Rust

6 DATE OF BIRTH (month, day, and year) July 17, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	54	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ins. Agent 01

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sussex Co. Delaware

PARENTS

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Jennie Joseph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant (Address) Records of Balto. City Hosp.

Filed 12-1 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-30

17 I HEREBY CERTIFY, That I attended deceased from 10-24-30, 19..., to 11-17-30, 19...,

that I last saw him alive on 11-17-30 19...,

and that death occurred, on the date stated above, at 6:35 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Autopsy

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

11-17 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Nov 20 1930

20 UNDERTAKER Wm J Tuckner & Sons

ADDRESS N. & Pa

TION is very important See instructions on back of Certificates.

Spec.—1-30—M. & T.—250 Blks.

E 62452

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62452

CERTIFICATE OF DEATH.

X 122-002

REGISTERED NO. 12-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. ..... WARD)

2-FULL NAME John J. Coniff

(a) RESIDENCE No. 915 Main St. Wheeling W Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 29 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Charlotte W. Coniff

6 DATE OF BIRTH (month, day, and year) June 28, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newberg W. Va.

PARENTS

10 NAME OF FATHER Peter Coniff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan Donohoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records
(Address)

15 Filed ..... 1930 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Nov 17, 1930, that I last saw him alive on Nov. 17, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver due to common duct obstruction

(duration) 2? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic nephritis (duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Wheeling W. Va.

Did an operation precede death? yes Date of Oct 27, 1930

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Ralph G. Hills, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wheeling W. Va.

DATE OF BURIAL Nov 17, 1930

20 UNDERTAKER Wm. J. Buckner Sons

ADDRESS North St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62453 E 62453

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Mosher ST. 16-23 (WARD)

2-FULL NAME Stephen L Brown

(a) RESIDENCE NO. 1004 Mosher ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 17 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Josephine Brown

6 DATE OF BIRTH (month, day, and year): DEC 24 1893

7 AGE: Years 36 | Months 10 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Jamaica B. W. I

PARENTS

10 NAME OF FATHER: John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Jamaica B. W. I.

12 MAIDEN NAME OF MOTHER: Mary McKenzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Jamaica B. W. I.

14 Informant (Address): Josephine Brown 1004 Mosher St

15 Filed NOV 13 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930, to Nov 15, 1930, that I last saw her alive on Nov 14, 1930, and that death occurred, on the date stated above, at 10. a m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvulitis
Nephritis
(duration) ..... unknown

CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) W. F. Howell M. D.
1930 (Address) 601 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Nov 18 1930

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 130 Freeman St

TION is very important. See instructions on back.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62454

E 62454

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 15-54 ST., WARD)

2-FULL NAME Gertrude Shipley

(a) RESIDENCE NO. 1631 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of William Shipley

6 DATE OF BIRTH (month, day, and year) January 11, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Peter Gould

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Charlotte Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed NOV 18 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-30

17 I HEREBY CERTIFY, That I attended deceased from 10-29-30, 19 , to 11-14-30, 19 , that I last saw her alive on 11-14-30, 19 , and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) yrs. 11 mos. da.

CONTRIBUTORY (Secondary) Auricular fibrillation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padgett, M. D.

11-15, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery

DATE OF BURIAL Nov 18 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

V 18 1930

TION is very important See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62455

E 62455

91-002

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2205 Druid Hill Ave) (WARD) 59

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Owens

(Residence in Baltimore: No. 2205 Druid Hill Ave St.: ....yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1862 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Basil Hayden

11-BIRTHPLACE OF FATHER (State or Country). Louisiana

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Richardson

(Address) 45 E. 131st St New York

15-

Filed ....., 191.... C. HANSON JONES, M. D. Registrar.

NOV 18 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 15, 1930 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1930, to Nov 15 1930, that I saw her alive on Nov 15 1930, and that death occurred, on the date stated above, at 12.20 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) T E Dansbury M. D.

Nov 17, 1930 (Address) 1602 Pauls Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Vincent de Paul's Cemetery

DATE OF BURIAL. Nov. 19, 1930

20-UNDERTAKER Thomas E. Kelson

ADDRESS 1301 Pennsylvania Ave

CAUSE OF DEATH must be stated in accordance with the International List of Causes of Death. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 62456 HEALTH DEPARTMENT—CITY OF BALTIMORE

100.001

E 62456

CERTIFICATE OF DEATH.

REGISTERED NO. E 62456

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Provident Hosp.

CITY OF BALTIMORE: (No. 654 Division St ST. 4 C. 25 WARD)

2-FULL NAME Elizabeth Johnson

(a) RESIDENCE NO. 640 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lucille Tayson (Address) 640 W. Saratoga St.

15 Filed OCT 16 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/17/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1930, to Nov 17, 1930, that I last saw her alive on Nov. 17, 1930, and that death occurred, on the date stated above, at 4 7/8 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pyloric Obstruction (duration) Undetermined

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Dr. George McDonald M. D.

11/17, 1930 (Address) 900 W. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W.B. Cultural Cem

DATE OF BURIAL 11 18 1930

20 UNDERTAKER Samuel Hawkins

ADDRESS 1201 Pennsylvania Ave.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62457

CERTIFICATE OF DEATH.

E 62457

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Rosecroft Terrace ST. WARD 30-21

2-FULL NAME Edward Stewart Williams

(a) RESIDENCE NO. 422 Rosecroft Terrace ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1877.

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
52	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Western Md. R. R.

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Stewart Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Cecelia Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Neil Q. Burgess.

(Address) 422 Rosecroft Terrace

15 Filed NOV 18 1930 C. Hampson Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1930, to Nov 15 1930, that I last saw h— alive on Nov 14 1930, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Contributory Chronic Nephritis

(duration) yrs. 6 mos. 21 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) James L. Fitzgerald, M.D.

19 (Address) 1724 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 11/18/30

20 UNDERTAKER Harry A. Wiltse

ADDRESS 4101 Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 62458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 62458

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 Penn ST. 4-30 WARD)

2-FULL NAME Leslie Cornbrooks

(a) RESIDENCE NO. 15 Penn ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Cornbrooks

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
28	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Dorchester Virginia

PARENTS

10 NAME OF FATHER Geo. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Harry Cornbrooks (Address) 15 Penn St

15 Filed 11/18 19 30 H. JACKSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV. 15 — 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 19 30, to NOV. 15 — 19 30, that I last saw h alive on NOV. 15 — 19 30 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At her home

Did an operation precede death? No Date of —

Was there an autopsy? No—

What test confirmed diagnosis? Clinical

(Signed) Edw. Pritchett M. D.

11/15 1930 (Address) 1200 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 11/18 1930

20 UNDERTAKER Curtis L. Williams

ADDRESS 324 N. Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-30—M. & T.—250 Bks.

62459 HEALTH DEPARTMENT—CITY OF BALTIMORE NE 62459

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) 9-47 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Henderson

(a) RESIDENCE NO. 714 Melville Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Rebecca

6 DATE OF BIRTH (month, day, and year) Feb 190[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER Isaac Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Lesser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Isaac Henderson (Address) 1930 Druid Park Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-30

17 I HEREBY CERTIFY, That I attended deceased from 11-3, 1930, to 11-17, 1930, that I last saw him alive on 11-17, 1930, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Purpura Hemorrhagica (Thrombocytopenic)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopn. type not det.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Milton B. Kirsh, M. D.

11/17, 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Nov 18 1930

20 UNDERTAKER Sol Shriner & Bro — ADDRESS 127 E Baltimore St

TION is very important. See instructions on back of certificates.

1-30—M & T.—100 B—50L

E 62460

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62460

CERTIFICATE OF DEATH

REGISTERED NO. 74-501

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 917 N. Kresson ST. 26-39 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Wehrheim

(a) RESIDENCE NO 917 N. Kresson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oct/4/1844

6 DATE OF BIRTH (month, day, and year) Oct 4/1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John P. Wehrheim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhemina Eh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry Wehrheim
(Address) 917 N. Kresson St

15 [illegible] 1930 HAMPSON JONES, M. D. Registrar

NOV 18 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

Nov 17 19 30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Nov. 20 1930

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St

1-30—M. & T.—100 B—50L

E 62461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 16-67

E 62461

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST. WARD)

2-FULL NAME William Lynch

(a) RESIDENCE NO 2901 Riggs Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Samuel Serio

9 BIRTHPLACE (city or town) (State or country) Phila., Pa.

PARENTS

10 NAME OF FATHER John Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila., Pa.

12 MAIDEN NAME OF MOTHER Elizabeth ---

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila., Pa.

14 Informant Samuel Serio
(Address) 2901 Riggs Ave

15 NOV 18 1930 HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D. (Coroner)

Nov. 17 1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C. A. Co

DATE OF BURIAL Nov. 18 1930

20 UNDERTAKER Margaret E Flynn

ADDRESS 1922 Light St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62462

E 62462

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 W. Lafayette Ave 66-68 (WARD)

2-FULL NAME Mrs Anna May Green

(a) RESIDENCE NO. 2500 W. Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louis Green

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Judge Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant W. Luther Wilson

(Address) 2500 W. Lafayette Ave

Filed DEC 4 1930, 19 C. HAMPSON JOHNS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1930, to Nov 16, 1930,

that I last saw her alive on Nov. 16, 1930,

and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Fracture Left Tibia (Both)

(duration) yrs. mos. 14 ds. (own)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Stevens, M. D.

11/16, 1930 (Address) 1901 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jews Cathedral Cemetery

DATE OF BURIAL 11/20/1930

20 UNDERTAKER Geo. Weber & Son

ADDRESS 2503 Edmondson Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 62463

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62463

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 N. Linwood ave ST., 6-11 WARD)

2-FULL NAME Wm W. c Alexander

(a) RESIDENCE NO. 127 N. Linwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie c Alexander

6 DATE OF BIRTH (month, day, and year) Oct 19 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Water Tester

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer Water Dept.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Thomas c Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Annie Lowrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Carrie c Alexander

(Address) 127 N. Linwood ave

15 [illegible]

NOV 18 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16/30

17 I HEREBY CERTIFY, That I attended deceased from June 1929 to Nov 16 1930, that I last saw h... alive on Nov 16 1930, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows: Chr Myocarditis

(duration) Chr Int Nephr. yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 127 N. Linwood

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Faure Jr M. D.

11 17 1930 (Address) 2939 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL Nov 19 1930

20 UNDERTAKER Philip Henrig

ADDRESS 2016 Eutaw St

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. ATION is very important.

Spec.—1-30—M. & T.—250 Bks.

E 62464

E 62464 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 516 Normandy Ave (WARD) 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C Jacobs

(a) RESIDENCE NO. 516 Normandy Ave STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of or WIFE of Geo Jacobs

6 DATE OF BIRTH (month, day, and year) Oct 4 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edw Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Shellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo Jacobs (Address) 516 Normandy Ave

15 Filed NOV 16 1930 H. G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to Nov 16th, 1930, that I last saw h alive on Nov 16th, 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) H. R Lucas, M. D.

11/17, 1930 (Address) 39 W Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL 11/18 1930

20 UNDERTAKER Edw Toulson ADDRESS Wash Blvd

NOV 16 1930

SEE INSTRUCTIONS ON BACK OF CERTIFICATE. See instructions on back of certificates. TION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

E 62465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 62465

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 W. Clement St. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie L. C. Swope

(a) RESIDENCE NO. 136 W. Clement ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob W. Swope

6 DATE OF BIRTH (month, day, and year): Nov. 21, 1875

7 AGE: Years 54 Months 11 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: ~~Unknown~~ Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Unknown~~ Unknown

12 MAIDEN NAME OF MOTHER: ~~Unknown~~ Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ~~Unknown~~ Unknown

14 Informant Mr. Jacob W. Swope
(Address) 136 W. Clement St

15 [illegible] JONES, M.D.

16 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1930 to Nov 16 1930

that I last saw her alive on Nov 16 1930

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Hypertension
Nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Gordon Lay M.D.

11/17/30

19 Address 800 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Nov. 19 1930

UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 N. Eutaw

NOV 18 [illegible]

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62466 ✓ E 62466

E 62466

CERTIFICATE OF DEATH.

X 74-001

REGISTERED NO. 76-21

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4940 Eastern Ave ST. WARD)

2-FULL NAME Thomas Gaujuld Mason.

(a) RESIDENCE NO. Green Spring Valley Hunt Club WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Hunt Club.

(c) Name of employer Green Spring Valley Hunt Club St Marys Co. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Marlton Mason.

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records. (Address) Balto City Hosp

15 Filed NOV 13 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov 15, 1930, that I last saw h~~e~~live on Nov 15, 1930, and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Rt.)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Generalized Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Harry Goldman M. D.

11/16 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery DATE OF BURIAL 11/19 1930

20 UNDERTAKER Wm H Thos H. Bailey 112 Jefferson St ADDRESS

CHECK CAREFULLY THE INFORMATION IN THIS CERTIFICATE. See instructions on back of certificates. ATTENTION is very important

NOV 13 1930

Spec.—1-30—M. & T.—250 Bks.

60-002

E 62467 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore Gen Hospital (ST.) (WARD) REGISTERED NO. 22324

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Clara Catherine Helaine

(a) RESIDENCE NO. 15 E. Heath ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John A Helaine

6 DATE OF BIRTH (month, day, and year) aug-8-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Whittington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER - not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant John A. Helaine

(Address) 15 E Heath st

15 Filed NOV 13 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1930, to Nov. 15, 1930, that I last saw h[illegible] alive on Nov 15, 1930, and that death occurred, on the date stated above, at 5 35 P m.

The CAUSE OF DEATH* was as follows:

Thyrotoxicosis (storm) with toxic adenoma of thyroid Post-operative

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Toxic adenoma thyroid

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov-13-'30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J Sullivan M. D.

, 19 (Address) 10 Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Nov 18th 1930

UNDERTAKER E Schlosman & Son

ADDRESS 1039 Hanover

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

NOV 13 1930

Spec.—1-10-21—M&T—1500 Blks.

E 62468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62468

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3120 (St.) N Wolfe (Ward) 15

2-FULL NAME Frank R Clapsaddle

(a) RESIDENCE NO. 3120 N Wolfe St., WARD 15

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) Md

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	38	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Frank M Kemp

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Clapsaddle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Striner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Anna Clapsaddle 3120 N Wolfe St

15 [illegible] Registrar

NOV 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/17 1930 to 11/18 1930.

that I last saw h[illegible] alive on 11/18 1930.

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) 6 hrs

CONTRIBUTORY (Secondary) Heart Disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas E Parker M. D.

, 19 (Address) 8122 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Town Md | DATE OF BURIAL Nov 20 1930

20 UNDERTAKER Josiah Keyser | ADDRESS [illegible]

MARGIN SHOULD BE CAREFULLY SUPPLIED. Any item may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62469

CERTIFICATE OF DEATH

E 62469

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1839 N. Duncan ST. 8-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cecelia Matthews

(a) RESIDENCE NO. 1707 N. Ellwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2y yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Clinton E Matthews

6 DATE OF BIRTH (month, day, and year): Oct 21—1884

7 AGE: Years 46. Months Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Geo. H. Pickering

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Lucilda Taprena

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Emanuel Pickering

(Address) 1839 N Duncan st

15 Filed NOV 18 1930 MAURICE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 16.—1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1930, to Nov. 16, 1930, that I last saw h[illegible] alive on Nov. 16, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach + Liver metastasis

about 1 yrs. 6 mos. ds. (duration)

CONTRIBUTORY (Secondary) Dr Pleis. about (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Seen by phy. before death.

(Signed) H. H. Stansbury, M. D.

Nov 18 1930 (Address) 714 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery DATE OF BURIAL Nov 19 1930

20 UNDERTAKER: Robt J Turner. ADDRESS 1942 N. Broadway

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 62470

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62470

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 20-28 ST. / WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Ganzman

(a) RESIDENCE NO. 543 S. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Marie Ganzman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdelene Sauerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed NOV 18 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-30

17 I HEREBY CERTIFY, That I attended deceased from 10-30-30, 19..., to 11-17-30, 19...,

that I last saw him alive on 11-17-30, 19...,

and that death occurred, on the date stated above, at 5:10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Anaemia, Secondary

(duration) yrs. ½ mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam. X-Ray.

(Signed) Paul Padget, M. D.

11-17-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov 20 1930

20 UNDERTAKER Wm. Miles & Sons Funeral Home

ADDRESS 2072 Madison Ave

CAUSE OF DEATH to be plainly written, no abbreviations or use of ditto marks. See instructions on back of certificates. TION is very important

Spec.—1-30—M. & T.—250 Bks

E 62471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ E 62471

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Asquith ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Thomas

(a) RESIDENCE NO. 912 Asquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced (or) WIFE of Henry Thomas

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Scott (daughter) (Address) 912 Asquith st.

15 Filed NOV 18 1930 [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1930 to Nov 16, 1930, that I last saw h[illegible] alive on Nov 15, 1930, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia + Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. K. Yandell M. D.

11/17 1930 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northumberland Co

DATE OF BURIAL Nov. 18 1930

20 UNDERTAKER R. E. Wilson

ADDRESS 1515 N. Eldersley st

CAUSE OF DEATH to be plainly written, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—9-30—A. & Co.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62472 E 62472

CERTIFICATE OF DEATH.

114

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3201 Elmora av ST. 8-40 WARD)

2-FULL NAME Thomas B. Hough Jr.

(a) RESIDENCE NO. 3201 Elmora av ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos ds. How Long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5-11-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thomas B. Hough

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Marie J. Hough

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Thomas B. Hough
(Address) 3201 Elmora av

15 [illegible] Registrar

NOV 13 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 30

17
I HEREBY CERTIFY, That I attended deceased from Nov 14 , 1930 , to Nov 16 , 1930
that I last saw him alive on Nov 16 , 1930
and that death occurred, on the date stated above, at 5-20 A m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) E Gill Hall M. D.
Nov 18 1930 (Address) 1631 E North av

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov 20 19
20 UNDERTAKER	ADDRESS
Geo J Roth Jr Esq	1730 Hanover

Spec.—9-30—A. & Co.—250 Bks.

E 62473 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62473

CERTIFICATE OF DEATH.

REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 S. Conkling St. WARD) 16-37

2. FULL NAME Emma F. Goldbeck

(a) RESIDENCE NO. 703 S. Conkling St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/13/1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Goldbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Goldbeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Elizabeth Goldbeck
(Address) 703 S. Conkling St

15 Filed 1930 By HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-30

17

I HEREBY CERTIFY, That I attended deceased from November 16, 1930 to November 17, 1930

that I last saw him alive on November 16, 1930

and that death occurred, on the date stated above, at 7:0 a m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs of death

(Signed) O. B. Bronushas M. D.
T. B. Bronushas M. D.

11-18-30 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Sepulchre Cem

DATE OF BURIAL 11/20 1930

20 UNDERTAKER Geo. J. Roth & Son

ADDRESS Baltimore Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 62474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 E 62474

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lydenham Hospital ST. 7-11 WARD)

2-FULL NAME Clara Roberts

(a) RESIDENCE NO. 807 No Linwood Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	66	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Roberts

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Ann Jane Baptisher

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mrs W. E. Webb
(Address) 807 N. Linwood ave

15 Filed NOV 18 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1930, to Nov. 18, 1930,
that I last saw her alive on Nov. 18, 1930,
and that death occurred, on the date stated above, at 2.40 A. m.

The CAUSE OF DEATH* was as follows:

Tonsilla Diphtheria

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerotic Cardiovascular disease (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 807 No Linwood Av

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Examination of throat

(Signed) L. Peter Mencher, M. D.

, 19 (Address) Lydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park cemetery — DATE OF BURIAL Nov 19 1930

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W North ave

NOV 18 1930

CAUSE OF DEATH to be plainly written. Do not use abbreviations or ditto marks. See instructions on back of certificates. TION is very important

Spec.—8-16-29—L. F. S.—100 Bks.

E 62475

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62475

CERTIFICATE OF DEATH

161-002

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Providence Hospital ST., 1-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant of Chas R. & Ruth Shipley

(a) RESIDENCE NO. 708 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Chas R Shipley

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Fowler

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Ruth Fowler Shipley
(Address) 708 Madison Ave

15 Filed NOV 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1930, to Nov 17, 1930, that I last saw h[illegible] alive on Nov 17, 1930 and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Asphyxiation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Transverse Presentation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. G. McLeod, M. D.

11/18, 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 11/18/1930

20 UNDERTAKER Mgr. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 62476 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62476

CERTIFICATE OF DEATH. X 118-002

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... St. 09 Ward)

2-FULL NAME Robert Dent

(a) RESIDENCE NO. 1 Fulton - Wd

(Usual place of abode) St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~: Mary

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 65 | Months – | Days – | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: labored 040

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Robert Dent

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Mariel Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Beulah (Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 19 C. [illegible] JOHNS, M.D. Registrar

V 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-12-30

17 I HEREBY CERTIFY, That I attended deceased from 11-8-, 1930, to 11-12-, 1930, that I last saw h[illegible] alive on 11-12-, 1930, and that death occurred, on the date stated above, at 245 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia – 4 days

Paralytic ileus – 2 days

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exploratory Laparotomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-8-30

Was there an autopsy?

What test confirmed diagnosis? –

(Signed) E. H. Compbell, M. D.

, 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: NOV 18 1930

UNDERTAKER: Commissioner Health.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly C... TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 62477

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62477

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 N. Montford Ave ST., 6-10 WARD)

2-FULL NAME Wm. L. Lloyd Jr.

(a) RESIDENCE NO 137 N. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Lloyd

6 DATE OF BIRTH (month, day, and year) May 2/1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Highway Dept
(c) Name of employer Balto. City

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. L. Lloyd, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Steindeufer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. L. Lloyd, Sr.

(Address) 137 N. Montford Ave.

15 Filed 18 1930, 192 SAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], Coroner, M. D.

Nov 17, 19 30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov 19 1930

20 UNDERTAKER Wm C Miller & Son

ADDRESS 2334 Jefferson St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 62478

239336.

Surg.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62478

CERTIFICATE OF DEATH.

15-59 117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. WARD)

2-FULL NAME James Liles

(a) RESIDENCE NO. 624 Gold ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work mechanic 086

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) N Carolina

PARENTS

10 NAME OF FATHER Clay Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Carolina

12 MAIDEN NAME OF MOTHER Liles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Carolina

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed NOV 18 1930, 19 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16-30

17

I HEREBY CERTIFY, That I attended deceased from 7-20-, 1930, to 11-16-, 1930,

that I last saw him alive on 11-16-, 1930,

and that death occurred, on the date stated above, at 6 40 a m.

The CAUSE OF DEATH* was as follows:

Sub-phrenic abscess - Rt.

Empyema - Rt.

Pericarditis effusion - Pleural effusion Left

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) - Retro cecal appendiceal abscess

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept. 24-1930

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) E. H. Compton, M. D.

11-18 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL 11/19 1930

20 UNDERTAKER Sam'l. W. Chase & Son

ADDRESS 1400 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 62479 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62479

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3658 Falls Road ST., 13 WARD 13-37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Kearney

(a) RESIDENCE NO. 3658 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Kearney

6 DATE OF BIRTH (month, day, and year): June 1863

7 AGE: Years 67 | Months 5 | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: Thomas Mayse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Julia Risner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Pearl E. Kearney

(Address): 3658 Falls Road

15 Filed NOV 18 1930, 19 — WILLIAM H. LAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 17-1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to Nov 17, 1930, that I last saw her alive on Nov 17, 1930, and that death occurred, on the date stated above, at 4 40 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) C. H. Richardson, M. D.

Nov. 1930 (Address) 858 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion, Freelands, Balto. Co.

DATE OF BURIAL: Nov. 19-1930.

20 UNDERTAKER: Horace F. Burgee

ADDRESS: 3631 Falls Road

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62180 E 62480

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 W Hamilton ST. 11-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie S Dandridge

(a) RESIDENCE No. 18 W Hamilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Philip P. Dandridge

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Robert G. Henry
(Address) Easton Md

15 Filed NOV 18 1930, 19 SAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Nov 17, 1930, that I last saw her alive on Nov 17, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emily B Hooker, M. D.

Nov 18, 1930 (Address) 24 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester Va

DATE OF BURIAL Nov 19 1930

20 UNDERTAKER Henry H. Jenkins Sons Co

ADDRESS Eastern Ave & Gay St

CAUSE OF DEATH in plain terms, so that it may be properly CODED. See instructions on back of certificates. This information is very important.

V 18 1930

OK M

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62481 ✓ 129 E 62481

E 62481 REGISTERED NO. 12-49

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3505 N. Charles ST., WARD)

2—FULL NAME Mary E. Bridges

(a) RESIDENCE NO. 3505 N. Charles ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Bridges

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gettysburg, Pa.

PARENTS

10 NAME OF FATHER David Wills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Jennie Smyser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mr. John S. Bridges

(Address) 3505 N. Charles St.

15 FILED NOV 18 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1923 to Nov 17, 1930, that I last saw her alive on Nov 15, 1930 and that death occurred, on the date stated above, at 2 50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Symptoms (duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

Nov, 19 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Nov. 19, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

M.B. Mitchell

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly examined.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62482 129 E 62482

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3130 Berkshire Road ST., 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CHARLES ROTH

(a) RESIDENCE NO. 3130 Berkshire Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Roth

6 DATE OF BIRTH (month, day, and year) August 18, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 0-30

(c) Name of employer Arundel Corporation

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Justus Roth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Miss Margaret Roth (Daughter)

(Address) 3130 Berkshire Road

15 NOV 18 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to Nov 17th, 1930, that I last saw him alive on Nov 17th, 1930, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory

(Signed) L. L. Gordy, M. D.

11-17, 1930 (Address) Hayord Rd & Overland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: Nov. 19, 1930

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: BALTIMORE ST. & BROADWAY.

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 62483

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62483

CERTIFICATE OF DEATH.

101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1633 N. Gay St. 8-16 (WARD)

2-FULL NAME Thomas J. Hamilton

(a) RESIDENCE NO. 1633 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (~~or WIFE of~~) Sarah E. Hamilton

6 DATE OF BIRTH (month, day, and year) March 25th 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah E. Prendergast

(Address) 1633 N. Gay St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Nov 17, 1930, that I last saw him alive on Nov 17, 1930, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur C. Manning M. D.

11/18, 1930 (Address) 800 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 11/20/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE or CONDITION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62484

CERTIFICATE OF DEATH

E 62484

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospitals St., 6-11 Ward)

2-FULL NAME Edward C. Eckert

(a) RESIDENCE NO. 3003 Philadelphia St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Eva V. Eckert

6 DATE OF BIRTH (month, day, and year) Oct 15th 1902

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
28	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Marine
(c) Name of employer Curtis Bay Tug Co.

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Bernard Eckert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Veffary

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Eva Eckert
(Address) 702 N. Bernard Ave

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the ~~evidence~~ obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Incision across throat severing R. Jugular veins & trachea

..... (duration) ..... yrs. ..... mos. 5 hrs.

CONTRIBUTORY (Secondary) (over)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Hepburn, M. D.

11 17 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	11/20/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS ... PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 18 1930

Spec.—1-30—M. & T.—250 Bks

Dr Damarco — Medical Arts Bldg — Vic 6675 ✓

E 62485

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62485

CERTIFICATE OF DEATH.

113

REGISTERED NO. 12-19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 N. Charles ST.) (WARD)

2-FULL NAME John F. Gaskin

(a) RESIDENCE NO. 2023 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/19/30

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Edward Gaskin

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Sinko

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Catherine E. Gaskin

(Address) 647 W. Fayette St

15 Filed NOV 18 1930, 19 SAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-16-, 1930, to 11-17-, 1930, that I last saw h[illegible] alive on 11-17-30, 19, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

infection

(Corrected) J. H. Coroner John J. Mooney

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) S. S.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. E. Guarnaccia, M. D.

11-17 19 30 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 11/19/1930

20 UNDERTAKER Wm Cook 1217 St Paul st

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

NOV 18 1930

Spec.—1-30—M. & T.—250 Blks.

E 62486 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62486

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Ensor St.) (10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wesley Harris

(a) RESIDENCE NO. 1115 Ensor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mollie E Harris

6 DATE OF BIRTH (month, day, and year) June 18-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James F. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary J Allwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mollie E Harris

(Address) 1115 Ensor St

15 [illegible] 16 HAMPSON JONES, M. D. Registrar

V 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1930, to Nov 18, 1930

that I last saw h... alive on 11/18, 1930

and that death occurred, on the date stated above, at 7-9 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstinal Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Myer, M. D.

11/18 1930 (Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Nov 20-1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Allens

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 62487 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62487

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N Linwood St., 6-11 Ward)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Keller

(a) RESIDENCE NO. 400 N Linwood ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth Keller

6 DATE OF BIRTH (month, day, and year) June 27-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	71	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabeth Keller
(Address) 400 N Linwood ave

Filed NOV 18 1930, 19__ SAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Nov 16, 1930.

that I last saw h[illegible] alive on Nov 16, 1930

and that death occurred, on the date stated above, at 12 45 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ____ yrs. ____ mos 4 ds.

CONTRIBUTORY (Secondary) Grippe (duration) ____ yrs. ____ mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Geo. Keller M. D.

11-18 1930 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Nov 19 1930

20 UNDERTAKER John Welch

ADDRESS 200 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 62488

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62488

CERTIFICATE OF DEATH

185

REGISTERED NO. 24-34

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1609 Belt St. (ST.) (WARD)

2-FULL NAME Mary Dach.

(a) RESIDENCE NO. 1609 Belt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ds. How long in U. S., if of foreign birth? 50 yrs. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If [redacted], widowed, of [redacted]
(or) WIFE of Conrad Dach.

6 DATE OF BIRTH (month, day, and year) January 1, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	10	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Pulaski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Elizabeth Homberg. (daughter)

(Address) 1609 Belt St.

15 Filed [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 16, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured femur, Accidental fall into street.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? October 18, 1930 Light & West Sts.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible], M. D. Coroner

11/18/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eden Hall

DATE OF BURIAL 11-19 1930

20 UNDERTAKER E. P. Harder

ADDRESS 115 E. West St.

INFORMATION, carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 62489

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

2-FULL NAME David Magee

(a) RESIDENCE NO. Lancaster Pk ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lewariner

6 DATE OF BIRTH (month, day, and year) Dec-12-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Magee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 Registrar JAMESON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-18-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 18, 1930, that I last saw him alive on Nov. 18, 1930, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis, bilat.
Uremia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H C Smith, M. D.

11/18 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Pa

DATE OF BURIAL 11/18 1930

20 UNDERTAKER Hughes Jones Inc.

ADDRESS 424 N Broadway

mation should be carefully supplied. Also state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 62490

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62490

CERTIFICATE OF DEATH

REGISTERED NO. 4-7+74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST. WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Daplyn.

(a) RESIDENCE NO Vineland N.J. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred en route. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Advertising manager.
(b) General nature of industry, business, or establishment in which employed (or employer) Walter L. Main
(c) Name of employer Circus.

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Report.

(Address)

15 Filed NOV 19 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 14, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Charles Hotel.
November 12, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas M. Reinhardt, M. D. Coroner

11/18/30 Address 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Nov 19 1930.

20 UNDERTAKER Stewart & Monroe

ADDRESS Balto

NOV 19 1930

28—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 62491 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 62491

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2621 Talbot Road ST. 28-65 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Waller Grafflin

(a) RESIDENCE NO. 2621 Talbot Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 63 yrs. 1 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced (HUSBAND of or) WIFE of: Hannette Lee Peyton Grafflin

6 DATE OF BIRTH (month, day, and year): Aug 5 1867

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Tobaccos

(c) Name of employer: Self-

9 BIRTHPLACE (city or town) (State or country): Chicago Ill

PARENTS

10 NAME OF FATHER: Geo. W. Grafflin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Illinois

14 Informant: Mrs Hannette L. P. Grafflin (wife)

(Address) 2621 Talbot Road

Filed NOV 19 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1930, to Nov 18, 1930, that I last saw him alive on Nov 17, 1930, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Cerebral Hemorrhage)

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Consultations

(Signed) Wilbur Cole, M. D.

NOV 18, 19 (Address) 2207 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: The Plains - Fauquier Co Va. DATE OF BURIAL: Nov 20 1930

20 UNDERTAKER: Stewart & Co Balto. ADDRESS

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

mation should be carefully supplied. Any

Spec.—0-30—A. & Co.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62492

122 dec'd 62492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 N. Milton Ave. St. 8-12 WARD)

2 FULL NAME George L. Gettermann

(a) RESIDENCE NO. 1202 N. Milton Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katharine G. Gettermann

6 DATE OF BIRTH (month, day, and year): Jan. 27, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co., Md.

PARENTS

10 NAME OF FATHER: Louis T. B. Gettermann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Gerhold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Elizabeth G. Ankenbauer, 1202 N. Milton Ave.,

15 Filed [illegible] 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 17, 1930

17 I HEREBY CERTIFY. That I attended deceased from Oct 18, 1930, to Nov 17, 1930

that I last saw h[illegible] alive on Nov 17, 1930

and that death occurred, on the date stated above, at 10.15a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Hypertrophic Cirrhosis of Liver

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B P Herzog M. D.

Nov 18 1930 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: NOV 20 1930

20 UNDERTAKER: John F Denny

ADDRESS: 715 Lig-ht St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

E 62493

REGISTERED NO. E 62493

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Thomas Ave St. 15-68 WARD)

2-FULL NAME Sarah Markowitz

(a) RESIDENCE NO. 1519 Thomas Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Markowitz

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria Hungary

10 NAME OF FATHER Mendel -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Hungary

12 MAIDEN NAME OF MOTHER Sarah -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria - Hungary

14 Informant (Address) J. Levine 1739 E Baltimore St

15 Filed NOV 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-30

17 I HEREBY CERTIFY, That I attended deceased from Oct-15- 1930 to Nov-18- 1930

that I last saw her alive on Nov. 18. 1930

and that death occurred, on the date stated above, at 4.5 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of large bowel (ascending colon)

(duration) not known yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) not known yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Hermann Sigler, M. D.

(Address) 2404 [redacted] Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew (Herring Run)

DATE OF BURIAL 11-19- 1930

20 UNDERTAKER Max Levine 1739 E.

ADDRESS Balto

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62494

CERTIFICATE OF DEATH

495

E 62494

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2101 Park Ave ST. 13-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Oliver Edward Janney

(a) RESIDENCE NO. 2101 Park Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne Janney

6 DATE OF BIRTH (month, day, and year) Mch. 8-1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 54

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Henry Janney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hannah Janney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Anne Janney

(Address) 2107 Park Ave

15 Filed NOV 19 1930 C. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1930, to Nov. 17, 1930, that I last saw him alive on Nov. 17, 1930 and that death occurred, on the date stated above, at 8 10 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left lung (primary)

(duration) yrs. 7 mos. ds. (?)

CONTRIBUTORY (Secondary) Terminal bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Illness began in England.

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) Thomas P. Sprigg, M. D.

Nov. 18, 1930 (Address) 1035 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Cemetery	Nov. 20 1930

20 UNDERTAKER Geo. E. Franck ADDRESS 802 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Prefixes, such as Mr., Mrs., Miss, should be omitted. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 62495 HEALTH DEPARTMENT—CITY OF BALTIMORE 92 E, 62495

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 N. Chester ST. 6-9 WARD)

2-FULL NAME Samuel Silversky

(a) RESIDENCE NO. 26 N Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rose Silversky

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER ~~Unk~~ Jos. Silversky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1431 Eutaw St

15 Filed NOV 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-19-30

17 I HEREBY CERTIFY, That I attended deceased from 11-19, 1930, to 11-19-, 19 30,

that I last saw h alive on ....., 19 .....,

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Acute Cardiac Dilatation

(duration) yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) .....yrs. .....mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Bernard Cohen, M. D.

, 19 (Address) 701 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodcrest Herman Hill Road

DATE OF BURIAL 11-19-1930

20 UNDERTAKER Jacob Lewis, 1431 Eutaw St

ADDRESS .....

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Esther M. Bozel

E 62496

1-30—M. & T.—100 B—50L

62496

HEALTH DEPARTMENT—CITY OF BALTIMORE

179

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital St. 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther M. Bozel

(a) RESIDENCE No. 3301 E. Gibbons St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 26/1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	1	22 21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Richard W. Bozel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Richard W. Bozell

(Address) 3301 E. Gibbons Ave

15 Filed NOV 16 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia-Burns over almost entire body. Clothes accidently ignited from kitchen gas range. on Oct 30/30

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D. Coroner

Nov 18/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Nov 20

DATE OF BURIAL 1930

UNDERTAKER [illegible]

ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

Spec.—1-30—M. & T.—250 Blks

E 62497

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62497

CERTIFICATE OF DEATH.

87

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 16-26 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Kleekamp

(a) RESIDENCE NO. 904 Edmondson Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 62

(c) Name of employer Morrow Bros.

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hosp.

NOV 19 1930

H. HANSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-30

17 I HEREBY CERTIFY, That I attended deceased from 11-11-30, 19..., to 11-17-30, 19..., that I last saw him alive on 11-17-30, 19..., and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:

Coronary occlusion

(duration) ... yrs. ... mos 11 da.

CONTRIBUTORY (Secondary) Pericarditis, acute

Edema (duration) ... yrs. ... mos. 11 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

11-17, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11/20 1930

UNDERTAKER J. C. Brannigan

ADDRESS 1136 Bolton St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS filling this CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62498

CERTIFICATE OF DEATH.

101-081

E 62498

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. (Balt.) 205 Canterbury St.; WARD) 18-29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Curry

(Residence in Baltimore: No. 205 Canterbury Street St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov (Month) 18 (Day), 1898 (Year)

7-AGE, 31 32 yrs. 11 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Robert Curry

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Alice Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Lewis

(Address) 032 Dover st.

15-

Filed..... 19.. Registrar

NOV 19 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 16 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1930, to Nov 16 1930, that I saw h[e] alive on Nov 16 1930, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia Lobar

.....

.....

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Contributory

..... (Duration) ....yrs. ....mos. 5 ds.

(Signed) Charles E. Horne M. D.

Nov 18..., 1930 (Address) 712 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. National Cemetery

DATE OF BURIAL, Nov 19.., 1930.

20-UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

Tapkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

4/VE 62499

CERTIFICATE OF DEATH

E 62499

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2504 Fait ave ST. ..... WARD) 1-3

2-FULL NAME William A. Tapking

(a) RESIDENCE NO 2504 Fait ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ida Tapking

6 DATE OF BIRTH (month, day, and year) Dec 23, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	10	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Am DeCarolina Co
(c) Name of employer Balto

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Frederick Tapking

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Virginia

12 MAIDEN NAME OF MOTHER Christena Mayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ida Tapking (Address) 2504 Fait ave

15 Filed ..... 192 ..... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Spinal Column
Fracture Skull & Cord

About (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) General Sepsis from open wound (duration) yrs. 16 mos. ds.

18 Where was disease contracted if not at place of death? Am DeCarolina Co

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D. Coroner

19 ..... (Address) 1006 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov. 19 1930

20 UNDERTAKER H. Sander Sons Inc — ADDRESS 1710 West N

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be carefully supplied.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62500

E 62500

CERTIFICATE OF DEATH

129

REGISTERED NO. 18-29

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1916 Lemon St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha S. Snyder

(a) RESIDENCE NO. 1916 Lemon St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm H. Snyder

6 DATE OF BIRTH (month, day, and year): Jan. 4, 1858

7 AGE: Years 72 Months 10 Days 13

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Wm H. Snyder (Address) 1916 Lemon St.

15 Filed NOV 19 1930 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 17. 1930. 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1930, to Nov 17, 1930, that I last saw he/she alive on Nov 17, 1930, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinic Analysis Etc.

(Signed) J. Rhee Norton, M. D.

11/19 1930 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial Nov. 19 1930

20 UNDERTAKER: Dunlap & Co. — ADDRESS 1024 N. Eutaw Ave

Spec.—1-30—M. & T.—250 Blks.

E 62501

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62501

CERTIFICATE OF DEATH.

129

REGISTERED NO. 12548

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home - Infirmary ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Julia R Haskell

(a) RESIDENCE NO. 327 Broston Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of John H. Haskell

6 DATE OF BIRTH (month, day, and year) April 24 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chester Pa
(State or country)

PARENTS

10 NAME OF FATHER Wm B Reaney

11 BIRTHPLACE OF FATHER (city or town) Phila
(State or country) Pa

12 MAIDEN NAME OF MOTHER Adaline Peters

13 BIRTHPLACE OF MOTHER (city or town) Phila
(State or country) Pa

14 Informant Crawford R. Haskell

(Address) 327 Broston Road

DEC 1 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18/1930

17 I HEREBY CERTIFY That I attended deceased from October 23, 1930, to Nov 18, 1930, that I last saw her alive on Nov 18, 1930, and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

Chronic myocarditis.

(duration) yrs 2½ mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Was anatomic confirmation obtained?

What test confirmed diagnosis Blood Examination Blood Chemistry

(Signed) James L. Owings Jr. M. D.

, 19 (Address) Church Home & Infirmary City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Buried Dec 1-1930 Virginia Beach Va

Green Mount Buried

DATE OF BURIAL Dec 3/31

20 UNDERTAKER Fuller 2435 Nov 20 1930

John H. Fuller

Henry H. Kirkus Sons & Orchard St

ADDRESS McCulloh

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62502

CERTIFICATE OF DEATH.

90 VE 62502

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 818 W. Fayette St. 18-26 (Ward)

2-FULL NAME Edwin Alberto

(a) RESIDENCE NO. 818 W. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a ~~Married~~, widowed, or ~~divorced~~

~~WIFE~~ HUSBAND of ~~of~~ Unknown

6 DATE OF BIRTH (month, day, and year) 3 March 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Commissioned Warrant Officer U.S.Navy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) East Killingly, Conn.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Lt. Comdr L.N.Linsley, USN

(Address) US Navy Recruiting Station, 6 E. Lexington St, Balto, Md.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to Nov 18, 1930, that I last saw h in alive on Nov 18, 1930, and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Stacy Leverman, M. D.

Nov 18 1930 (Address) 2621 Vineland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington, Washington DC

DATE OF BURIAL Nov. 20, 1930

20 UNDERTAKER Martin Fisher & Sons

ADDRESS 1827 W. North Ave

086

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62503 46 ✓ to Blandy E 62503

REGISTERED NO. 76-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S Macon ST ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie D. Korn.

(a) RESIDENCE NO. 318 S Macon St ST. 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of George Korn.

6 DATE OF BIRTH (month, day, and year) Aug-4 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	3 4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Torrace L. Kendall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dora Kolb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant George Korn Husband

(Address) 318 S Macon St

15 [illegible] C. HAMILTON JONES, M. D. Registrar

191930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16/1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1929, to Nov 16, 1930, that I last saw h er alive on Nov. 16, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastesis in Bladder (Unknown)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1929

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Frank A. Glentz, M. D.

Nov. 17, 1930 (Address) 3246 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetary

DATE OF BURIAL Nov. 20 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62504

CERTIFICATE OF DEATH

11-002 E 62504

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4303 Ready Ave ST., 27-47 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah E. Roache

(a) RESIDENCE NO. 4303 Ready Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of P. J. Roache

6 DATE OF BIRTH (month, day and year) March 9th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Hoxford Co. (State or country) Md.

PARENTS

10 NAME OF FATHER James McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Malinda Thomas

13 BIRTHPLACE OF MOTHER (city or town) Hoxford Co (State or country) Md.

14 Informant Minnie Roche

(Address) 4303 Ready Ave

FILED 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) November 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 14th, 1930, to Nov 17th, 1930

that I last saw her alive on Nov 17th, 1930

and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Geo. Turgotroy III M. D.

11/18/1930 (Address) 401 E 25th St

State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL 11/20/1930

20 UNDERTAKER J. J. Moran

ADDRESS 300 E Balto St.

E 62505 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62505

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. 944 Cold Spring St. 27-53 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Bailey Harrison

(Residence in Baltimore: No. 944 Cold Spring Lane St.; yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widow(er), or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: Dec 27 (Month) (Day) 1854 (Year)

7-AGE: 75 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Nurse (b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE (State or Country): Balto Co Md

PARENTS

10-NAME OF FATHER: Dr Geo W Bailey

11-BIRTHPLACE OF FATHER (State or Country): Balto.

12-MAIDEN NAME OF MOTHER: Sarah Ann Fitz

13-BIRTHPLACE OF MOTHER (State or Country): Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jane B. Powell

(Address) 944 Cold Spring

15- Filed 1930 C. CAMPBELL JONES, M.D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov (Month) 18 (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John J. Manning M. D. (Coroner)

11/19 1930 (Address) 26 E 22 Roland

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge DATE OF BURIAL: Nov 20 1930

20-UNDERTAKER: H Rudnick for ADDRESS Norma

Every important statement should be answered. See instructions on back of certificate.

Spec—9-30—A & Co—250 Blks

E 62506 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 62506

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 255 N. Hoffman St (WARD) 11-24

2 FULL NAME Charles Wright.

(a) RESIDENCE No. 255 N. Hoffman ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Jessie Wright.

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) White Oak Ga.

PARENTS

10 NAME OF FATHER Moses Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Coulcown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Coulcown.

14 Informant Jessie Wright. (Address) 255 N. Hoffman St

15 [illegible] 19 HAMPSON JONES, M. D. Registrar

1 91930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17-30

17 I HEREBY CERTIFY, That I attended deceased from Nov-15 . 1930 . to Nov-17 . 1930

that I last saw him alive on Nov. 17. 1930

and that death occurred, on the date stated above, at 1-40 m

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) ...

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pettigrew M. D.

. 19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edenwah Ga. DATE OF BURIAL 11/19 30

20 UNDERTAKER Samuel Hensley ADDRESS N Bidd St

Spec.—1-30—M. & T.—250 Bks.

E 62507

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62507

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 12-50 WARD)

2-FULL NAME William Camper

(a) RESIDENCE NO. 2224 Barclay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Florence Camper

6 DATE OF BIRTH (month, day, and year): Aug 5 1878

7 AGE: Years 52 | Months 3 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Camper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Gabrielle Scriven

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Clyde Soper (Address): 605 Cue Baltimore

15 Filed ..... 19 ..... Registrar

C. BAMFORD JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-18-30

17 I HEREBY CERTIFY, That I attended deceased from 11-18, 1930, to 11-18, 1930, that I last saw him alive on 11-18, 1930, and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar + Broncho-pneumonia (Types undetermined)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton B Cirsh, M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: My Loudon Park

DATE OF BURIAL: 11/21 1930

20 UNDERTAKER: W.M. Cook

ADDRESS: 1217 E Fayette St

Spec.—1-30—M. & T.—250 Bks

E 62508 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 1622 90 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella V. Sandy

(a) RESIDENCE NO. 1120 N. Monroe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 18, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER William Sands

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Harriet Sanford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Records of Balto. City Hospitals

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-30

17 I HEREBY CERTIFY, That I attended deceased from 6-25-29, 19, to 11-18-30, that I last saw her alive on 11-18-30, 19, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease.
Arteriosclerotic.
(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home. 2. Hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Podgt. M. D.

11-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 11/20/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

19930

Spec.—1-30—M. & T.—250 Bks

E 62509 HEALTH DEPARTMENT—CITY OF BALTIMORE

93 E 62509

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 1120 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Hetzner

(a) RESIDENCE NO. none (1301 Maryland Ave) ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan. 31, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Ret'd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Hetzner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Volmar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 9 1930 19 Dec. C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-30

17 I HEREBY CERTIFY, That I attended deceased from 6-8-29, 19, to 11-18-30, 19, that I last saw him alive on 11-18-30 19, and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

Embolism, pulmonary.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Varicose of legs.

(duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Hospital Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget. M. D.

11-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 11/20/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

E 62510 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62510

90

CERTIFICATE OF DEATH

1-PLACE OF DEATH Baltimore City Hospital

CITY OF BALTIMORE: (NO. 2-4 ST. / WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Brown

(a) RESIDENCE NO. 251 S Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of John T. Brown

6 DATE OF BIRTH (month, day, and year) Nov 13, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Roberts ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Susan ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md.

14 Informant Rynolds Baltimore City Hosp.
(Address)

15 Filed 12 1930 19 C. HAMPSON JONES, M.D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-30

17 I HEREBY CERTIFY, That I attended deceased from 10-20, 1930, to 11-18-1930, that I last saw h[illegible] alive on 11-18-1930, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis acute and Chronic.

(duration) Unknown

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Fred M. Overholt M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 11/20 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

27 E 62511 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62511

27

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-18 WARD)

2-FULL NAME John Shrader

(a) RESIDENCE NO. 1515 Lamont ST. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md—

PARENTS

10 NAME OF FATHER George Shrader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md—

12 MAIDEN NAME OF MOTHER Catherine Dorsey Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md—

14 Informant Records

(Address)

DEC 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1930, to Nov. 18, 1930, that I last saw him alive on Nov. 18, 1930, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Meningitis

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Pneumonia ?

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) A. G. Kettner, M. D.

, 19 (Address) J. Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/20 1930

20 UNDERTAKER Henry H. Mears & Son

ADDRESS 608 N. Calvert

Spec.—1-30—M. & T.—250 Bks.

E 62512

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62512

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Wilkens & Caton Aves ST. ..... WARD)

2-FULL NAME Mrs Marie Russell Lansdowne

(a) RESIDENCE NO. Second & Washington Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Elmer Russell

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila

PARENTS

10 NAME OF FATHER John F. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mariamy Gallery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Mrs Elmer E. Russell

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1930, to Nov 18, 1930,

that I last saw h.e alive on Nov 18, 1930,

and that death occurred, on the date stated above, at 4 40 a m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart Disease
-Mitral Stenosis

Lobar Pneumonia (duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert Stevens, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Phila Pa

DATE OF BURIAL Nov 21 1930

20 UNDERTAKER Charles L. Stevens

ADDRESS 1501 E Fort Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 62513

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-00

E 62513

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2117 Madison Ave ST., 13-59 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Young

(a) RESIDENCE NO. 2119 Madison Ave ST., WARD

(Usual place of abode) about three weeks Ltf (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Young

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	71	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Harford Co.

PARENTS

10 NAME OF FATHER Jarrett Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Sarah Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Husband

(Address) 717 Gold St.

15 DEC 1 1930 19 NRA Registrar

C. KARSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11—18—30

17 I HEREBY CERTIFY, That I attended deceased from 11/1/30, 19..., to 11/18/30, 19..., that I last saw h.. alive on 11/17/30, 19..., and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ✓ yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis

(duration) ✓ yrs. ✓ mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) W. H. Barksdale, M. D.

11/18/30 (Address) 526 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Long Green Md. St. Johns Ben

DATE OF BURIAL 11/20/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1601 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Blks.

E 62514

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62514

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N. Lanvale ST. 16-23 WARD)

2-FULL NAME Willie V. Hughes.

(a) RESIDENCE NO. 1023 N. Lanvale ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry

6 DATE OF BIRTH (month, day, and year) ? ? 1883

7 AGE: 47 Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Robert Lavington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Dollie Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Odell Plenty 1023 N. Lanvale St.

Filed 19 1930 . 19 . Registrar OK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 . 1930 . to Nov 17th 1930. that I last saw her alive on Nov 17th 1930, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:
Chr. Carcinomatous Nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Lauenbagh M. D.

(Address) 2218 N. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boston Va.

DATE OF BURIAL 11/20/1930

ADDRESS

20 UNDERTAKER Mrs. Geo. H. Holland 1631 Druid Hill Ave

THIS is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62515 ✓ 90 E 62515

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH Md. Gen Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15-68 WARD)

2—FULL NAME Fred Schnell

(a) RESIDENCE NO. 1808 Ashburton ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

✓

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17th 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.. min.
20		3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jason L. Schnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Vincent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Clinical records

(Address) [redacted]

15 Filed NOV 19 1930 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1930, to Nov 18, 1930, that I last saw h/m alive on Nov 18, 1930 and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

1. mitral stenosis
2. mitral insufficiency
3. myocarditis insuff 1 deg.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert V. Chenault, M. D.

(Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 11/21/30

20 UNDERTAKER Geo Leimbach — ADDRESS 518 W Lexington St

Spec.—1-30—M. & T.—250 Bks.

ALDER

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62516

E 62516

CERTIFICATE OF DEATH.

10

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Austin Alder

(a) RESIDENCE NO. 5252 Candelia Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Alder

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Wildemann

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Maryland

14 Informant Hospital Record

(Address)

Filed ....., 19.....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1930, to Nov. 18, 1930, that I last saw him alive on Nov. 18, 1930, and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Tonsil and Laryngeal Diphtheria

(duration) 0 yrs. 0 mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? 5252 Candelia Av.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Throat Cultures

(Signed) L. Peter Meranchi, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Nov. 20. 1930.

20 UNDERTAKER Horace F. Burgee

ADDRESS 363 Falls Road

19 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62517 ✓

E 62517

CERTIFICATE OF DEATH

89

REGISTERED NO. 4-75

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 W Saratoga ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily C. Lafferty

(a) RESIDENCE NO. 409 W Saratoga ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lafferty

6 DATE OF BIRTH (month, day, and year) Nov 16 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Warren C Gorman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Honey Mendle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Martha Long

(Address) 2436 Eastern Ave

15 Filed 19 Registrar

191930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1930, to Nov 18, 1930, that I last saw h alive on Nov. 18, 1930 and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

1 Angina Pectoris (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation Pulse

(Signed) L. M. Deuel M. D.

(Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 11/21 1930

20 UNDERTAKER Wm Cook — ADDRESS 2117 E Pratt St

1-30—M. & T.—100 B—50L

E 62518

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62518

CERTIFICATE OF DEATH

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1840 E. 28th ST., 9-46 (WARD)

2-FULL NAME Ermst A. H. Baark

(a) RESIDENCE NO 1840 E. 28th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Heun Baark

6 DATE OF BIRTH (month, day, and year) Oct 30/1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	0	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Miller Bros

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Johann Baark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Johanna Heun Baark

(Address) 1840 E. 20th St.

15 Filed ..... 192 ..... Registrar

1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation- Sarcoma of Thyroid

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D. Coroner

Nov 19/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 11/21 1930

20 UNDERTAKER Mullan Corp

ADDRESS 1217 St Paul St

Spec. 2-29-28

E 62519

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

E 62519

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Hosp ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Wenderoth

(a) RESIDENCE NO. 2848 Rayner Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of William W Wenderoth

6 DATE OF BIRTH (month, day, and year) May 2, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER John J. O. Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget O. Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

PARENTS

14 Informant William H. Wenderoth

(Address) 2848 Rayner Ave

15 Filed 19 Registrar

1 91930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/30

17 I HEREBY CERTIFY, That I attended deceased from 11/18, 1930, to 11/18, 1930, that I last saw her alive on 11/18, 1930, and that death occurred, on the date stated above, at 11.05 P.m.

The CAUSE OF DEATH* was as follows:

Mechanical Obstruction (Cause Unknown)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Cashman, M. D.

19 (Address) West Baltimore Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 11 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul

HAMPSON-JONES

Spec.—1-30—M. & T.—250 Blks

Eglehart
1403 Park Ave

E 62520

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62520

CERTIFICATE OF DEATH.

7 7½ to 8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 Bolton St. 14-20 (WARD)

2-FULL NAME Frederick D. Kaussmann

(a) RESIDENCE NO. 1515 Bolton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aimee W. Kaussmann

6 DATE OF BIRTH (month, day, and year) July 14 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Rev C. F. A. Kaussmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Beta Lampe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Aimee W. Kaussmann
(Address) 1515 Bolton St

15 Filed 9 1930, 19 HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1930 to Nov 18, 1930, that I last saw h[illegible] alive on Nov 18, 1930, and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Mitral Insufficiency.
(Pulmonary Edema).
(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Calcified Bronchitis with Tuberculosis mesenteric (?).
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical Ludwigs

(Signed) J H Woody, M. D.

, 19 (Address) 1403 Park ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 11/20 1930

20 UNDERTAKER W M Cook

ADDRESS 1217 E Fayette St

Spec.—1-30—M. & T.—250 Bks.

E 62521 HEALTH DEPARTMENT—CITY OF BALTIMORE 124 ✓

CERTIFICATE OF DEATH.

E 62521

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST. 9-47 WARD)

2-FULL NAME Leonora Guyton

(a) RESIDENCE NO. 513 E. 41st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John H. Guyton

6 DATE OF BIRTH (month, day, and year) March 13-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER Fayette Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) London Co Md

12 MAIDEN NAME OF MOTHER Leonora Tepper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant John H. Guyton

(Address) 513 E. 41st St.

15 Filed 20 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-19-30

17 I HEREBY CERTIFY, That I attended deceased from 11-10, 1930 to 11-19, 1930

that I last saw her alive on 11-19-30, 19....,

and that death occurred, on the date stated above, at 4 P M m.

The CAUSE OF DEATH* was as follows:

Obstruction of Common Bile Duct with severe Jaundice

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Secondary Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 11-11-30

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) H. Kirk Lord M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood cemetery

DATE OF BURIAL Nov 22 1930

20 UNDERTAKER George N. Zibell

ADDRESS 1737 E. Eager St.

Spec.—1-30—M. & T.—250 Blks.

James E Smith

E 62522 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62522

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) President Hospital ST. 14-20 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E Smith

(a) RESIDENCE NO. 115 Chesapeake Ave ST., Annapolis Md WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md. U.S.A.

PARENTS

10 NAME OF FATHER Earnest Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis U. S. A.
12 MAIDEN NAME OF MOTHER Catherine Smith
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis U. S. A.

14 Informant Earnest Smith
(Address) Resident Md.

15 Filed 20 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-10, 1930, to 11-20, 1930, that I last saw h[e] alive on 11-20, 1930, and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:
Ruptured Appendix
Fecal Peritonitis

(duration) yrs. 4 mos 10 ds.

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of 6-10-30
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical

(Signed) J E Jones M. D.
20, 1930 (Address) President Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis, Md.
DATE OF BURIAL Nov 22 1930
ADDRESS Annapolis Md

20 UNDERTAKER Chas E Tucker Jr

Spec.—2-29-28—L. F. S.—500 Bks.

E 62523

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62523

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH

REGISTERED NO. 5-55

CITY OF BALTIMORE: (No. 3722 Reisterstown Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Morris

(a) RESIDENCE NO. 3722 Reisterstown Road WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) March 29 1889

7 AGE 41	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER David Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mary Morris

(Address) Wife

15 Filed NOV 20 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 30

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930 to Nov 19, 1930

that I last saw him alive on Nov 19, 1930

and that death occurred, on the date stated above, at 3459 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consultation

(Signed) David Orwin M. D.

11/19 1930 (Address) 1224 Eutaw St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd — DATE OF BURIAL Nov. 20 1930

20 UNDERTAKER Goldstein Brinson & Bro — ADDRESS 1127 E Balto St

Spec.—1-30—M. & T.—250 Bks

E 62524 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62524

40

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hosp. ST. [illegible] WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME William Taylor.

(a) RESIDENCE NO. 907 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Hannah Taylor

6 DATE OF BIRTH (month, day, and year) Feb 22 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Polisher

(b) General nature of industry, business, or establishment in which employed (or employer) Garage.

(c) Name of employer Fidelity Motor Co. Carlin Co

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Simon Taylor. ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Maria Staley ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Balto City Hosp.

15 Filed [illegible] 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-30

17 I HEREBY CERTIFY, That I attended deceased from 11-18-, 1930, to 11-18, 1930, that I last saw h— alive on 11-18-, 1930, and that death occurred, on the date stated above, at 9 50 A m.

The CAUSE OF DEATH* was as follows:

Multiple Strictures
Missing extirpation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? yes Date of 11-17-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings

(Signed) Fred M. Dunkerley, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL 11 21 30

20 UNDERTAKER Edward C. Hensley

ADDRESS W. Balto

Spec.—8-16-29—L. F. S.—100 Bks.

E 62525

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62525 1930 65 1865

101-08

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1136 N Carey ST. 16-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nathaniel A Pyms

(a) RESIDENCE NO. 1136 N Carey St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary E Pyms

6 DATE OF BIRTH (month, day and year) May 7 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 4008 Ridgewood Ave

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS:

10 NAME OF FATHER John A Pyms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary E Pyms

(Address) 1136 N Carey

15 Filed ..., 19... Registrar

NOV 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1930, to Nov 19, 1930, that I last saw h[illegible] alive on Nov 19, 1930, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) ... yrs. ... mos. 0 ds.

CONTRIBUTORY (Secondary) As Pneumonia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? None Date of —

Was there an autopsy? No

What test confirmed diagnosis? Anatomic Symptoms

(Signed) C. B. Howell, M. D.

Nov 22 1930 (Address) 712 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Nov 22 1930

20 UNDERTAKER — ADDRESS

Laurence E Hoffman Co

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 ✓

E 62526 — REGISTERED NO. E 62526

1-PLACE OF DEATH

City of Baltimore: (No. 2609 Washington ~~Boulevard~~ St. ~~(Ward)~~ 18 12

2-FULL NAME Meredith L. Warrington

(a) RESIDENCE NO. 2609 Washington Boulevard Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Gertrude Warrington

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	23	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country) Victor Warrington

PARENTS

10 NAME OF FATHER Victor Warrington

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Del -

12 MAIDEN NAME OF MOTHER Estelle Marvil

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Victor Warrington
(Address) 2609 Washington Boulevard

15 Filed ..... 19.... Registrar

NOV 20 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
following a Fall Sept 24/30
fracturing C 5 & 6 Cervical Vertebrae
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. A. Brosius M. D.
Nov 18 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 11/20/30

20 UNDERTAKER Edw. Fawlor

ADDRESS Druid

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 62527

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002 E 62527

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 N Carlton St. 5-9 WARD)

2-FULL NAME Charles Gibson

(a) RESIDENCE NO. 622 N Carlton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth Gibson

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Gen

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Abraham Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Caldwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Gibson
(Address) 622 N Carlton St.

15 Filed NOV 20 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Nov 17, 1930, that I last saw h... alive on Nov 17, 1930, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction
2 days

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Surgical

(Signed) [illegible], M. D.

11-19-1930 (Address) 501 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Nov 20 1930

20 UNDERTAKER Lothe Gross

ADDRESS 140 Fairland Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 ✓ E 62528

E 62528

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals ST. 72-31 WARD)

CITY OF BALTIMORE: (NO. _____

2-FULL NAME Christine Philips

(a) RESIDENCE NO. 842 S. Chapel ST., _____ WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) June 7, ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60 ?		5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Peter Philips

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Hunt

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Brooks Funeral City Hosp. (Address) Baltimore City Hosp.

15 Filed _____, 19 _____ Registrar _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-30

17 I HEREBY CERTIFY, That I attended deceased from 6-9-, 1930, to 11-18-, 1930, that I last saw her alive on 11-18-, 1930, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of vulva.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia. (duration) 1 yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Fred M. Overhall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Nov 19 1930

20 UNDERTAKER H. R. Brown & Son

ADDRESS New Windsor

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62529

CERTIFICATE OF DEATH

90

E 62529

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enroute Hopkins Hospital ST. 6-10 WARD)

2-FULL NAME Edward Klotsch

(a) RESIDENCE NO 5 N. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto/Md.

PARENTS

10 NAME OF FATHER Ferdinand Klotsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Wm Schwartz

(Address) 2609 E. Fairmount Ave

15 Filed Nov 20 1930 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

Nov 20/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 11/21 1930

20 UNDERTAKER Philip Herwig

ADDRESS 3016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62530 | 129 | E 62530

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 N. Dallas St. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Daly

(a) RESIDENCE NO. 420 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Cl.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles White

6 DATE OF BIRTH (month, day, and year): [redacted] 1852

7 AGE: Years 78 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mr. Edward White

(Address) 420 N. Dallas St.

15 Filed 26 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-17-30

17 I HEREBY CERTIFY, That I attended deceased from 11-17, 1930, to 11-17, 1930

that I last saw her alive on 11-17, 1930

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal Disease.

— (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Butler, M. D.

19 (Address) 425 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion

DATE OF BURIAL: Nov 20, 1930

20 UNDERTAKER: Mrs. R. A. Elliott

ADDRESS: 715 Aisquith

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62531 X 129 E 62531

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Southern Hospital St. 17-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Vinton McCoy-

(a) RESIDENCE No. Reisterstown Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) June 16 - 1842

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm McCoy

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Miss Grace McCoy
(Address) Reisterstown Md

15 Filed [illegible] Registrar

DEC 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19-1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to Nov. 19, 1930, that I last saw her alive on Nov. 18, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Some time yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Hoen, M. D.

11-19, 1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Bur	Nov 21 1930
20 UNDERTAKER Wm Bergman Sons	ADDRESS 2238 N Mts

Spec.—1-30—M. & T.—250 Bks.

E 62532

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 ✓ E 62532

CERTIFICATE OF DEATH.

REGISTERED NO. 27-42

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (NO.) St. Joseph's Hospital ST., WARD

2-FULL NAME Emeran Milton Trimble

(a) RESIDENCE NO. 611 Everell Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 1930

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
/	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Milton Trimble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Loretta Fischer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Milton Trimble (Address) 611 Everell ave

15 Filed ..... 19 ..... Registrar

20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30.

17 I HEREBY CERTIFY, That I attended deceased from 11-18, 1930, to 11-20, 1930, that I last saw h[illegible] alive on 11-20-30, 19..... and that death occurred, on the date stated above, at 6.10 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Atelectasis Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Lawrence Cleary, M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov 21 1930

ADDRESS 37 S. Amity St

20 UNDERTAKER Mc W & E Duppel Inc

Spec.—1-10-21—M&T—1500 Blks.

E 62533 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 129 E 62533

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3500 Mary Ave., Baltimore, Md. ST., 27th WARD 27+43

2-FULL NAME George Henry Gerhold

(a) RESIDENCE NO. 3500 Mary Ave., Baltimore, Md ST., 27th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Mary Gerhold (née Borleis)

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	------	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... Cigar-maker (retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Henry Gerhold

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Siebert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant John H. Gerhold

(Address) 6504 Fairdel Ave., Baltimore

15 Date 20 1930 19 H. LEVERTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1930, to Nov. 18, 1930, that I last saw him alive on Nov. 17, 1930, and that death occurred, on the date stated above, at 11:50 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage - 4 days

Arterio-sclerosis- many years

Chronic Nephritis- many years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema 24 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson M. D.

11/18 1930 (Address) A. L. Wilkinson, 5713 Belair Rd., Raspeburg, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashwood Cemetery DATE OF BURIAL Nov. 21 1930

20 UNDERTAKER Frederick Lassahn Sons ADDRESS 7401 Belair Rd.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62534

CERTIFICATE OF DEATH.

13 E 62534

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wear

(a) RESIDENCE NO. 219 N High ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) ? 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Md

PARENTS

10 NAME OF FATHER Alex Wear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland

12 MAIDEN NAME OF MOTHER Margaret Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records (Address)

15 DEC 20 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30

17 I HEREBY CERTIFY, That I attended deceased from 11-10, 1930, to 11-19, 1930, that I last saw h[illegible] alive on 11-19 1930, and that death occurred, on the date stated above, at 10[illegible] m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Colitis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical - autopsy

(Signed) J. Leyko, M. D.

11/20, 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Nov 20/30

ADDRESS

20 UNDERTAKER Stewart & Mowen Co. 128 W. North Ave

Spec.—1-30—M. & T.—250 Blks

✓ E 62535

E 62535

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 11-7 WARD)

2-FULL NAME Frances David Sanner

(a) RESIDENCE NO. 605 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 0 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Alice Sanner

6 DATE OF BIRTH (month, day, and year) Oct 21 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James B Sanner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Maria Bentley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital Records (Address)

15 Filed C. HAMPSON JONES, Registrar

NOV 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-30

17 I HEREBY CERTIFY, That I attended deceased from 11-17, 1930, to 11-18, 1930, that I last saw him alive on 11-18, 1930, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Feyko, M. D.

11/18, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross. Harford Rd

DATE OF BURIAL Nov 21 1930

20 UNDERTAKER J. J. Tucker & Sons

ADDRESS Catonsville

Spec.—1-30—M. & T.—250 Bks

E 62536 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 62536

CERTIFICATE OF DEATH.

REGISTERED NO. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No.) Catonsville ST. 19-29 (WARD)

2-FULL NAME John Butler

(a) RESIDENCE NO. 1322 N Lombard ST., _____ WARD _____ (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	-	-	

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work Railroad. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. and O. R. R.

9 BIRTHPLACE (city or town) Balto Md
(State or country) ~~Ireland~~

PARENTS

10 NAME OF FATHER John Butler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Egan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Mary Butler
(Address) Woodside, Silver Spring, Md.

15 [illegible] 19 C. HAMPSON JONES, M. D.
0 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930 to Nov 19, 1930, that I last saw h.. alive on Nov 19, 1930, and that death occurred, on the date stated above, at 9:15 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of prostate

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer lungs & metastasis

(duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) [illegible] M. D.

11/19 30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

UNDERTAKER [illegible]

DATE OF BURIAL Nov. 22 1930

ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 62537

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62537

CERTIFICATE OF DEATH

Mary. Ann. Thornton

REGISTERED NO. 10-14

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 E. Biddle ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary. Ann. Thornton

(a) RESIDENCE NO. 929 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

6 If married, widowed, or divorced (or) WIFE of Charles F Thornton

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Michael Cavanaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

Informant Charles F. Thornton

(Address) 929 E. Biddle St.

Filed 20 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1930, to Nov 19, 1930

that I last saw her alive on Nov 19, 1930

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart Disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D Di Stefano, M. D.

Nov 20, 1930 (Address) 407 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Nov. 22 1930

20 UNDERTAKER Henry Hoch & Sons Inc. ADDRESS 301 E Eager St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62538

E 62538

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Oregon WARD) 11

2-FULL NAME Sister Mary Borgia O.S.F.

(a) RESIDENCE NO. St Joseph Hospital WARD Baltimore Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1-12-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	10	7	6

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Religious work
(b) General nature of industry, business, or establishment in which employed (or employer) Nuns 65
(c) Name of employer Church

9 BIRTHPLACE (city or town) (State or country) Minersville, Pa.

PARENTS

10 NAME OF FATHER Richard Eastwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Minersville Pa.

12 MAIDEN NAME OF MOTHER Mary Kurwick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Minersville Pa

14 Informant (Address) Hospital Records

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-18-30

17 I HEREBY CERTIFY, That I attended deceased from 11-16-30, 19....., to 11-18-30 19....., that I last saw h alive on 11-18-30 P.M. and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:
Atapexy - Hy pertension (with Hemiplegia)
(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of None
Was there an autopsy? no
What test confirmed diagnosis? Clinical Course
(Signed) M.D.
, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Nov. 22nd 1930

20 UNDERTAKER Henry Hauck Sons, Inc. — ADDRESS 1301 E Eager

Spec.—1-30—M. & T.—250 Bks.

E 62539 ✓ E 62539

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62539 × 49

CERTIFICATE OF DEATH.

12-51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U.S. Marine Hospital

CITY OF BALTIMORE: (No. Baltimore, Md. ST. WARD)

2-FULL NAME Samuel T. Rhodes

(a) RESIDENCE NO. Prince William Hotel, Manassas, Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mattie Gaines

6 DATE OF BIRTH (month, day, and year) Feb 18 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wilkes County

(State or country) Ga.

PARENTS

10 NAME OF FATHER John D. Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilkes Co., Ga.

12 MAIDEN NAME OF MOTHER Fanida D. Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elbert Co., Ga.

14 Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

15 Filed ....., 19.... C. RAMPSON JONES, M. D. Registrar

D 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1930, to November 19, 1930, that I last saw him alive on November 19, 1930, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Sarcomatosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Gordon A. Abbott M. D.

11/19/30 (Address) U.S. Marine Hospital, Balto., Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington Ga.

DATE OF BURIAL 11/20/30

20 UNDERTAKER Harry H. Leitzke

ADDRESS 410 E. Lanvale St.

Spec.—1-30—M. & T.—250 Bks.

E 62540 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62540

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospital St. 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Jane Brownell

(a) RESIDENCE NO. Margaret Gilden House St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ppd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mary Brownell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant

Filed ....., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1930, to November 16, 1930, that I last saw her alive on November 16, 1930, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Premature

9 wks (duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Enteritis (duration) ....yrs. 1 mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M B Kerr, M. D.

, 19 (Address) Univ Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M.D. Commissioner of Health

NOV 20 1930

NOV 20 1930

Spec.—1-30—M. & T.—250 Bks

E 62541 ✓ E 62541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21-28 161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1416 Carroll ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Dixon

(a) RESIDENCE NO. 1416 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, 1 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Maryland
(State or country)

PARENTS

10 NAME OF FATHER Clarence Dixon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Calvert, County, Md.

12 MAIDEN NAME OF MOTHER Irene Marshall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant

(Address)

15 Filed 1930 By HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1930, to Nov. 17, 1930, that I last saw h. living alive on Nov. 17, 1930, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A. Klopstock, M. D.

11/17 1930 (Address) Univ. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

NOV 20 1930

Spec.—1-30—M. & T.—250 Bks

E 62542 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62542

CERTIFICATE OF DEATH.

REGISTERED NO. 1610

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 769 Dover St. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Jones

(a) RESIDENCE NO. 769 Dover Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 8. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address)

DEC 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1930, to Nov. 9, 1930, 19..,

that I last saw her alive on Nov. 8, 1930, 19 30,

and that death occurred, on the date stated above, at 8 H. m.

The CAUSE OF DEATH* was as follows:

~~Premature Birth~~

Prematurity - 27 weeks

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Maternal Cause

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12-10-1930 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

NOV 2 01930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62543

CERTIFICATE OF DEATH

90 E 62543

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 N. Castle St ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Frank Simunek

(a) RESIDENCE NO. 1025 North Castle St ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 2 mos. 19 ds. How long in U. S., if foreign birth? 28 yrs. 2 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): July 30. 1902

7 AGE — Years: 28 | Months: 3 | Days: 19 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore City

10 NAME OF FATHER: Joseph Simunek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Cathrine Vokroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: John Simunek

(Address): 1025 N. Castle Street

15 0 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 19. 1930

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1930, to November 19, 1930, that I last saw him alive on November 19, 1930, and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows:

Streptococcus Viridans Septicemia, with Bacterial Endocarditis and Mitral Valve Insufficiency (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) Simon N. Monreal, M. D.

. 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer Cemetery — DATE OF BURIAL: Nov 22 1930

20 UNDERTAKER: August Pasek — ADDRESS: 2406 Ashland Ave.

Spec.—1-30—M. & T.—250 Bks.

E 62544
262762

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62544

CERTIFICATE OF DEATH.

X 90

Med

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 1-9 WARD)

2-FULL NAME Julius Dillworth

(a) RESIDENCE NO. Glen Ann Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence (in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

6a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie McGowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Govanda.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

01930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30

17 I HEREBY CERTIFY, That I attended deceased from 11-18-, 1930, to 11-20-, 1930, that I last saw him alive on 11-20-, 1930, and that death occurred, on the date stated above, at 1:10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hospital

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Caroline L. Bedell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fork M. E. Cem

DATE OF BURIAL Nov 23 1930

20 UNDERTAKER Clarence E. Cutler

ADDRESS Fork Md.

Spec.—1-30—M. & T.—250 Blks.

E 62545 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62545

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore ST., Gilbert WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Leonard

(a) RESIDENCE NO. 241 East Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced (or) WIFE of HUSBAND of Mrs Leonard

6 DATE OF BIRTH (month, day, and year) May 22 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work stage hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Connecticut

10 NAME OF FATHER John Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Mrs Katherine Leonard

(Address) 241 E. Federal St

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1930, to Nov. 19, 1930, that I last saw h alive on Nov. 14, 1930, and that death occurred, on the date stated above, at 10 15 a.m.

The CAUSE OF DEATH* was as follows:

Partial Intestinal Obstruction

Fecal Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Carcinoma of Cecum

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 13-1930

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) T. J. Sullivan, M. D.

, 19 (Address) S. Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney

DATE OF BURIAL 11/22/1930

20 UNDERTAKER E. V. Fanning Store - 1938 E. Lafayette Ave

ADDRESS

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62546

CERTIFICATE OF DEATH

59-002

E 62546

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 N. Dallas ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael F. Defazio

(a) RESIDENCE NO 1803 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 13, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Saml Defazio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mildred Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

Informant Saml. Defazio

(Address) 1803 N. Dallas St

Filed ..... 192 ..... Registrar

21 1930 [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Congenital Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Ellis Carter, Coroner, M. D.

Nov. 19 1930 (Address) 501 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 11-21 1930

20 UNDERTAKER George J. Ruth Inc

ADDRESS 1730 Harlem Ave

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62547

31 E 62547

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2614 Springhill Ave ST.) 15-58 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Causey A. Dobres

(a) RESIDENCE NO. 2614 Springhill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Anna DOBRES

7 DATE OF BIRTH (month, day, and year) 10-30-1895

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Buffalo N. Y.

10 NAME OF FATHER Abraham Dobres

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bella -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address) S. Lewis 1439 E Balto St

File No. 21 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1928 to Nov. 20 1930,

that I last saw him alive on Nov. 19 1930,

and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

① Hodgkin's disease

② Pulmonary TB.

Patient 2 yrs. mos ds.

(duration)

CONTRIBUTORY (Secondary) TB. meningitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? Yes Date of Jan. 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Max Ziegler, M. D.

11/20, 1930 (Address) 1001 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Hebrew Rm

DATE OF BURIAL 11 21 1930

20 UNDERTAKER M. R. Lewis

ADDRESS 1439 E Balto

Spec.—1-12-23—M&T—500 Blks.

E 62548 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 62548

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2727 Madison ST. 16-68 WARD)

2-FULL NAME Catherine E. Blake

(a) RESIDENCE NO. 2727 Madison ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry W. Blake

6 DATE OF BIRTH (month, day, and year) July 12-1867

7 AGE Years 63 | Months 4 | Days 6 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country) Pat Rotterdam Ireland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

PARENTS

14 Informant Mary W. Blake
(Address) 2727 Madison St.

15 1930 —, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1930, to Nov 18th, 1930, that I last saw her alive on Nov 17th, 1930, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) I B Emerbaum, M. D.

11/19/1930 (Address) 1401 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral | DATE OF BURIAL 11/21 1930

20 UNDERTAKER H. C. Blanning | ADDRESS 1136 Bolton Ave

Spec.—1-30—M. & T.—250 Bks.

62549

HEALTH DEPARTMENT—CITY OF BALTIMORE

62549

CERTIFICATE OF DEATH.

REGISTERED NO. 2512

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Hickory & Catonsville ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Howard Brown

(a) RESIDENCE No. Old Frederick Rd. ST., Baltimore Co. Catonsville WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Bertha Brown

7 DATE OF BIRTH (month, day, and year) May 12 1888

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	6	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Thomey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Ed M. Tormey

(Address) Edmondson City Md

Filed DEC 1 1930 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov 20, 1930, that I last saw h alive on Nov. 20 1930, and that death occurred, on the date stated above, at 1040 a.m.

The CAUSE OF DEATH* was as follows:

1 Chronic suprarenal degeneration with decompensation

2 Chronic glomerular nephritis

(duration) years yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) Hjalmar E Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park Cem

DATE OF BURIAL 11/22/30

20 UNDERTAKER Forget Furey Sulton

ADDRESS Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 62550

REGISTERED NO. E 62550

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 E. Fort Ave. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Anna Houghtling.

(a) RESIDENCE NO. 734 E. Fort Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Infant.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

DATE OF BIRTH (month, day, and year) June 26, 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4.	23.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John W. Houghtling.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary A. Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Mary A. Houghtling.

(Address) 734 E. Fort Ave.

Filed ..... 19 ..... Registrar

211930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1930 - 9.45 AM

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1930, to Nov. 20, 1930, that I last saw h[illegible] alive on Nov. 19, 1930 and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia

(duration) 6 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Contusions (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) Wm. T. Seabury M. D.

11.20, 1930 (Address) 436 East Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Nov 21 1930

20 UNDERTAKER A. Howard Evans ADDRESS 388 Hart Ave

Spec.—9-30—A. & Co.—250 Blks.

E 62551 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 62551

101-007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No) 906 (ST) Park Av (WARD) 11-24

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Turner

(a) RESIDENCE NO. 906 (ST.) Park Av (WARD)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE — Years: 52 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Teamster 023
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank Turner
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Clara Core
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Agnes Stewart 906 Park Av

15 Filed 21 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-19-30

17
I HEREBY CERTIFY, That I attended deceased from Nov 12 — 1930, to Nov 19 — 1930
that I last saw h in alive on Nov 18 1930
and that death occurred, on the date stated above, at 1-30 A m
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.
CONTRIBUTORY (Secondary) none
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical
(Signed) Chas. J Keller M. D.
11/24/1930 (Address) 2216 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov 23 1930

20 UNDERTAKER: Frank D Kemsley — ADDRESS: 5781 Biddle

E 62552

1-30—M 42 T—100B—50L

E 62552

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185

REGISTERED NO. E 62552

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hos. ST., 7-19 WARD)

2-FULL NAME Louis LaRue

(a) RESIDENCE No. 623 North Pont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of (Late) William LaRue

6 DATE OF BIRTH (month, day, and year) May 14th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Dennis Stonesifer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westminster Md

12 MAIDEN NAME OF MOTHER Amelia Luttin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster Md.

14 Informant Arthur L. Stonesifer

(Address) Westminster Md

15 NOV 21 1930 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Pelvis, fall down ben over stairs Accident

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D. Coroner

12, 1930 (Address) 200 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 11/22/1930

ADDRESS

UNDERTAKER Eng. Weber & Son 2503 Edmondson

Cor.—10-30-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 62553

REGISTERED NO. E 62553

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 62553

1-PLACE OF DEATH

City of Baltimore: (No. 1045 W Mulberry St.) (18-16 Ward)

2-FULL NAME Catherine McColgan

(a) RESIDENCE NO. 1045 W. Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John McColgan

6 DATE OF BIRTH (month, day, and year) March 27 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	7	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jas. H. Donnelly
11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)
12 MAIDEN NAME OF MOTHER Brigget Ford
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant John McColgan
(Address) 1045 W Mulberry

15 Filed NOV 21 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Obstruction of Bowels
Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas H Brooks M. D.
Nov 20 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Nov 22 1930

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

Spec.—1-30—M. & T.—250 Bks.

E 62554

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62554

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph's Hospital (WARD)

CITY OF BALTIMORE; (No.) ST.

2-FULL NAME Mary Geary

(a) RESIDENCE NO. 36 E. Henrietta St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	Female	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Charles J. Carey

DATE OF BIRTH (month, day, and year) Aug 31-1866

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Michael Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Conley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Lawrence Carey

(Address) 36 E. Henrietta St

Registrar

NOV 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/19/30

17 I HEREBY CERTIFY, That I attended deceased from 11-16-30, 19..., to 11-19-30, 19...,

that I last saw h alive on 11-19-30, 19...,

and that death occurred, on the date stated above, at 5.00 P. m.,

The CAUSE OF DEATH* was as follows:

(a) Chronic Myocarditis with Cardiac Dilatation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Lawrence Hynes M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Nov 23 30

20 UNDERTAKER F. A. Kramer & Son — ADDRESS 703 Hamilton St

Spec.—2-29-28—L. F. S.—500 Bks.

E 62555

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 62555

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1014 N Payson ST. 16-22 WARD)

2—FULL NAME Emanuel C Pickering

(a) RESIDENCE NO. 1014 N Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

Left

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 16 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none, ret'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Geo T Pickering

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lucie de Lapuda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

Informant Robt E Hoffman

(Address) 1014 N Payson at

Filed NOV 21 1930 C. HAMPSON JONES, M. D. (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1930, to Nov. 19, 1930, that I last saw him alive on Nov. 17, 1930 and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum & bladder

about (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

about (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? P.M. examination

(Signed) H. H. Staudenmayer, M. D.

Nov. 20 1930 (Address) 714 Park Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Nov 24 1930
20 UNDERTAKER Robt L Turner	ADDRESS 1642 Broadway

Spec.—1-30—M. & T.—250 Bks

E 62556

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62556

CERTIFICATE OF DEATH.

× 101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hosp ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Reichert Jr

(a) RESIDENCE NO. 7701 Oak Ave ST., WARD Parkville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) June 23rd 1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	1	4	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Frank C.D. Reichert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Muriel L. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Frank C.D. Reichert

(Address) 7701 Oak Ave Parkville

Filed NOV 21 1930

C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30

17 I HEREBY CERTIFY, That I attended deceased from 11-17, 1930, to 11-20, 1930, that I last saw him alive on 11-20, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos 4 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Feyko, M. D.

11/21, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL Parkwood Cem DATE OF BURIAL Nov 22 1930

UNDERTAKER E. Sahlaman & Son ADDRESS 1039 Fremont

Spec.—1-30—M. & T.—250 Bks

E 62557 ✓ E 62557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST., 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Gray

(a) RESIDENCE NO. 725 School ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced (a) HUSBAND of or) WIFE of Lida

DATE OF BIRTH (month, day, and year) Feb. 14, 1872

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer odd jobs

BIRTHPLACE (city or town) Greenville

(State or country) S.C.

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S.C.

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S.C.

Informant Records of

(Address) Balto. City Hosp.

Filed 21 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-30

17 I HEREBY CERTIFY, That I attended deceased from 9-26-30, 19, to 11-17-30, 19,

that I last saw him alive on 11-17-30, 19,

and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease,

Arteriosclerotic.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

Anginal (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Hospital 1. hour.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Podgel., M. D.

11-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 11-21 1930

20 UNDERTAKER Virginia A. Brooks

ADDRESS 1433 N Carey St

Spec.—8-16-29—J. F. S.—100 Bks.

E 62558

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62558

90

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2039 E.32nd ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Miller,

(a) RESIDENCE NO. 2039 E.32nd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Miller,

DATE OF BIRTH (month, day, and year) Sept. 19. 1852

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	2	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Henry Pflug,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Henry Miller
(Address) 2039 E. 32nd St

Filed 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 20 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1930, to Nov. 20 1930, that I last saw h[illegible] alive on Nov 20 1930 and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Robert S. Kirk, M.D.

11/20, 1930 (Address) 3126 Hartford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL NOV 22 1930

20 UNDERTAKER Robert S. Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—2-29-28—L. F. S.—500 Bks.

E 62559

E 62559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George A. Fox

(a) RESIDENCE NO. 2815 Overland ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Carr Fox

DATE OF BIRTH (month, day, and year) Oct 23 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	0	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Winggiat

(c) Name of employer Va.

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Geo G. Fox

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Susan Means

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

Informant Josephine V. Fox

(Address) 1907 Cedric Road

Filed Nov 21 1930 19 C. HAMPSON JONES, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Nov 21, 1930

that I last saw him alive on Nov 21, 1930

and that death occurred, on the date stated above, at 9 05 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus & Gangrene

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Oct 16 1930

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory.

(Signed) Cleo D Stiles Jr M. D.

19 (Address) Bon Secours Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery | DATE OF BURIAL Nov 24 1930

20 UNDERTAKER John C. Mitchell Sons ADDRESS Mt. Eutaw Place

Spec. 8-16-29—L. P. S.—100 Bks.

E 62560

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62560

CERTIFICATE OF DEATH

129

REGISTERED NO. 27-55

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6314 Wirt ave ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Ambrose

(a) RESIDENCE NO. 6314 Wirt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Ambrose

DATE OF BIRTH (month, day, and year) Feb 14 - 1871

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Frank Cemetiano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Michela Piamonto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Vincent Ambrose

(Address) 6314 Wirt ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1928, to Nov. 19, 1930, that I last saw her alive on Nov. 19, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

Cardiac Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. D. Frantsen, M. D.

. 19 (Address) 92 Biddle st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov 22 1930

20 UNDERTAKER Frank Cracco & Son

ADDRESS 1146 Eutaw st

Spec.—1-30—M. & T.—250 Bks.

Cornish

E 62561

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62561

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 807 Ashland Ave ST. 10-14 WARD)

2-FULL NAME Willemeania Cornish

(a) RESIDENCE NO. 807 Ashland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C.	Single.

If married, widowed, or divorced
HUSBAND of
or) WIFE of .....

DATE OF BIRTH (month, day, and year) [illegible] 1876

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mary Cornish

(Address) 807 Ashland Ave

Filed 11 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 19 - 30

17 I HEREBY CERTIFY, That I attended deceased from Nov 12/30, 19..., to Nov 19, 1930,

that I last saw h-- alive on Nov 19, 1930,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Ch Myocarditis

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. G. Hamilton, M. D.

11/21, 1930 (Address) 733 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL Nov. 21, 1930

ADDRESS 1720 Ashland Ave

20 UNDERTAKER Mrs. R. G. Elliott

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62562

100-001 E 62562

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 Stirling ST. 10-14 WARD)

2—FULL NAME Rose Bell

(a) RESIDENCE NO. 804 Stirling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7yr. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	widow

If married, widowed, or divorced HUSBAND of (or) WIFE of John Bell

DATE OF BIRTH (month, day, and year) June-03-1888

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	5	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Henry Harding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rosetta Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Viola Jones

(Address) 431 Aisquith St.

Filed 21 1930 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930, to Nov 20, 1930, that I last saw her alive on Nov 20, 1930 and that death occurred, on the date stated above, at 6:55 A. m.

The CAUSE OF DEATH* was as follows:

acute Bronchial Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hornstein, M. D.

11/21, 1930 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Nov. 24 1930
20 UNDERTAKER	ADDRESS
Chas. N. Johnson	416 N. Carolina St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 62563

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62563

CERTIFICATE OF DEATH

101-001

REGISTERED NO. 24-35

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1427 (St.) Woodall (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E Lambert

(a) RESIDENCE NO. 1427 Woodall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Edwina M Lambert

DATE OF BIRTH (month, day, and year) Dec 16 1889

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40	11	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist at

(b) General nature of industry, business, or establishment in which employed (or employer): Glenn Martin

(c) Name of employer: Middle River. Balto Co.

BIRTHPLACE (city or town) (State or country) Danielson Conn

10 NAME OF FATHER Edward Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

Informant Mrs Edwina M Lambert

(Address) 1427 Woodlawn st

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14 1930 to Nov. 20 1930

that I last saw h/M alive on Nov 20 1930

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. L. Campbell M. D.

11/21 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Worcester. Mass. DATE OF BURIAL Nov 22 1930

20 UNDERTAKER John F Denny ADDRESS 715 L. g t St

Spec.—1-30—M. & T.—250 Bks.

62564

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62564

45

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary (St.) (Ward)

2-FULL NAME John Neidhardt

(a) RESIDENCE NO. 2311 E. Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND) of or) WIFE of Elizabeth C Neidhardt

DATE OF BIRTH (month, day, and year) Aug 26 1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	2	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 631

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs Gertrude B Neidhardt

(Address) 2311 E Lafayette Ave

Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20/30

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to Nov 20, 1930, that I last saw h[illegible] alive on Nov. 20, 1930, and that death occurred, on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma Retroperitoneal

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation (duration) yrs. 6 mos. 28 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4/26/30

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Section

(Signed) J. Frank Hewitt, M. D.

11/20, 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mountain View Cem. Sharpsburg Md

DATE OF BURIAL NOV 22 1930

20 UNDERTAKER John Denny

ADDRESS 715 L St SE

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62565

CERTIFICATE OF DEATH

46 E 62565

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 16 WARD)

2—FULL NAME Nellie Shannon

(a) RESIDENCE NO. 700 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of George L. Shannon

DATE OF BIRTH (month, day, and year) Nov. 17, 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
(68)	68	0	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER John H. Dennison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louise McCarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Hospital records

(Address)

Filed 21 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Nov. 20, 1930, that I last saw her alive on Nov 20, 1930, and that death occurred, on the date stated above, at 7 00 P m.

The CAUSE OF DEATH* was as follows:

Squamous cell Carcinoma of cervix - Uteri

(duration) 6 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/29/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Albert K. Clements, M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Nov 24 1930

20 UNDERTAKER Wm. J. Fickert & Son

ADDRESS N. Pa Ave

Spec.—1-30—M. & T.—250 Bks

E 62566

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62566

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 76-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME William F. Eastin

(a) RESIDENCE NO. Homeless ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced (HUSBAND of or) WIFE of Lucille Eastin

DATE OF BIRTH (month, day, and year) Mar. 11, 1873

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	6	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer odd jobs

BIRTHPLACE (city or town) (State or country) Quincy Ill.

10 NAME OF FATHER William B. Eastin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Susan Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant (Address) Record of Balto. City Hosp.

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30

17 I HEREBY CERTIFY, That I attended deceased from 11-2-30, 19 ..., to 11-20-30, 19 ...,

that I last saw him alive on 11-20-30, 19 ...,

and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Dementia, senile, presenile form.
(duration) more than yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

11-21, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Nov. 22, 1930

ADDRESS

20 UNDERTAKER Wm. J. Tickner & Son

ADDRESS 1118 Pa Ave

Spec.—7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 62567

REGISTERED NO. E 62567

E 62567

1-PLACE OF DEATH

City of BALTIMORE: (No. 3905 Forrester St. Ward 27-41

2-FULL NAME Henry Anna Horr

(a) RESIDENCE NO. 3905 Forrester St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: William Horr

6 DATE OF BIRTH (month, day, and year): Oct. 14 1867

7 AGE: Years 63 Months 1 Days 5 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER: John P. Moller

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Sweden

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant (Address): William Horr 3905 Forrester

C. HAMPSON JONES, M. D. Registrar

NOV 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16 1930 to Nov. 18 1930

that I last saw her alive on Nov. 18 1930

and that death occurred, on the date stated above, at 5 15 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Primary Pernicious Anemia

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted —

if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edgar P. Sandrock, M. D.

(Address) Medical Arts 131 dg.

19 Nov 19 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — Date of Burial Nov 22 1930

20 UNDERTAKER: Jas E. Miller & Son — ADDRESS 2354 Jefferson St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62568

E 62568

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 523 East ST. 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alivia Yates

(a) RESIDENCE NO. 523 East ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April-10-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24 yrs	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work & Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs. Lifton

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Simon Yates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER Maria Elliot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Sister-Margaret Yates (Address) 523 East St.

Filed Nov. 21 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1930, to Nov -20-, 1930, that I last saw h~~er~~ alive on Nov -19-, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tb (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Laryngeal Tb (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) N. J. Dandor M. D.

, 19 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery DATE OF BURIAL: Nov. 22 19 30

20 UNDERTAKER: Chas. H. Johnson ADDRESS: 446 N. Carlton St

Spec. 2-29-28—L. F. S.—500 Bks.

E 62569

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62569

CERTIFICATE OF DEATH

REGISTERED NO. 15-61

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2200 Garrison Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sadie H. Carland

(a) RESIDENCE NO. 2200 Garrison Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Carland

DATE OF BIRTH (month, day, and year) ------

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	--	--	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Thomas H. Sheehan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah J. Connolly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

Informant Neal Sheehan

(Address) 2200 Garrison Avenue

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1930

17 I HEREBY CERTIFY, that I attended deceased from Nov 17 1930 to Nov 20 1930,

that I last saw h Sy alive on Nov 20 1930

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilitation of heart (duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Infected throat - suppurative Streptococcus ↑ 3 days (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? clinic

(Signed) Vernon J. Kelly M. D.

11/20 1930 (Address) 608 Somerset Road

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 11/24 1930

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 802 N. Calvert

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62570

E 62570

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 S. Bethel St. ST 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jadwiga Szatkowska

(a) RESIDENCE NO. 706 S. Bethel St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced (or) HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1868

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Chas. Mikolajczak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Josephine Borowski

(Address) 706 S. Bethel ST.

1930 C. 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1930, to Nov. 20, 1930, that I last saw h[illegible] alive on Nov. 20 1930, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Mitral Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/20, 1930 (Address) 2574 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Stanislaus [illegible] Nov 22 1930

20 UNDERTAKER — ADDRESS

John M Weber 401 S. Chester St

1-30—M. & T.—100 B—50L

E 62571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

198 E 62571

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Enroute Hopkins Hospital ST. 10-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Hickman

(a) RESIDENCE NO 729 N. Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joe Hickman

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rocky Mount N.C.

PARENTS

10 NAME OF FATHER Willie Merritt

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Nannie huston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Blanche Jackson

(Address) 918 Ashland Ave

15 Filed 12 1 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage-Stab wound left lung.

Homicide- Inquest Nov 21/30

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 729 N. Eden St.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [illegible], M. D. Coroner

Nov 21/30 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rocky Mount N.C.

DATE OF BURIAL 11-21 19 30

20 UNDERTAKER Byrom & Wright 1218 E. Eldersly St

ADDRESS

Spec. — 1-30 — M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62572

E 62572

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1721 Wilkens Ave. (St.) 19-28 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada May Schminke

(a) RESIDENCE No. 1721 Wilkens Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles B. Schminke

DATE OF BIRTH (month, day, and year) Oct. 17, 1877.

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	1	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Thomas Appler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Mahr

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

Informant Mr. Charles B. Schminke

(Address) 1721 Wilkens Ave.

Filed NOV 21 1930, 19

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1930 to Nov 20, 1930,

that I last saw her alive on Nov 19, 1930,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Kidney Disease

(duration) 5 yrs. mos da

CONTRIBUTORY (Secondary) Valvular Heart Disease (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No, Clinical

What test confirmed diagnosis?

(Signed) A C Cramer M. D.

11/21, 1930 (Address) 1701 Fawcett Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 11/22/30

20 UNDERTAKER Harry A. Witzke Edmondson — ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62573

188-193 V

E 62573

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hos. St., 18-26 (Ward)

2-FULL NAME Mary R Stiles

(a) RESIDENCE NO. 309 N. Carey St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur H King

6 DATE OF BIRTH (month, day, and year) 7-23-1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	3	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Robinson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary M. Black

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Arthur H King
(Address) 309 N. Carey St

15 Filed ....., 19.... C. LAWRENCE JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down while running across street in front of street car) and was run over by auto that struck her.

CONTRIBUTORY (Secondary) a Fract Skull (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Carey & Fayette

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. H. Hamm M. D.

11/20 1930 (Address) 3939 N. Eldorado

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 11/24 1930

ADDRESS St Paul St

UNDERTAKER Wm. Cook & Co

NOV 21 1930

Spec.—8-16-29—L. F. S.—100 Blks.

S. Waldron 210 E Preston

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62574

CERTIFICATE OF DEATH

90 E 62574

REGISTERED NO. 12-19

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1817 St Paul ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Schmidt

(a) RESIDENCE NO. 1817 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 28, 1846

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	0	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Dr Jacob Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Harry S. Locke

(Address) 1817 St Paul St

Filed DEC 21 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 29th, 1930, to Nov. 20th, 1930.

that I last saw her alive on Nov. 18th, 1930

and that death occurred, on the date stated above, at 8.-45 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 15 min.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Tests.

(Signed) D. A. Waldron, M. D.

, 19 (Address) 210 East Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 11/24/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Lane

1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62575 31 E 62575

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. ST. 21-29 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wernsdorfer

(a) RESIDENCE NO. 1127 Wicomico st. ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Feb. 15, 1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	9	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER John Wernsdorfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Stark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Hospital Records

(Address)

C. HAMPSON JONES, M.D.

Filed DEC 21 1930 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1930, to Nov. 21, 1930, that I last saw him alive on Nov. 21, 1930, and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos da.

CONTRIBUTORY (Secondary) Intestinal tuberculosis

(duration) Unknown yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jeune, M. D.

11-21 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetary

DATE OF BURIAL 11/24/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62576

CERTIFICATE OF DEATH

47

E 62576

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Md. Gen. Hospt. ST. 4-7 WARD)

2—FULL NAME Lillian Holden

(a) RESIDENCE NO. 15 E. Pleasant st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 1, 1870

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	9	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER D.L. Holden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Martha Pentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

Informant Hospital records

(Address)

Filed 21 1930 .19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30

17

I HEREBY CERTIFY, That I attended deceased from 11-13, 1930, to 11-20, 1930,

that I last saw her alive on 11-20, 1930

and that death occurred, on the date stated above, at 3.04 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Right Breast

?

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post-operative shock

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 11/18/30

Was there an autopsy? No

What test confirmed diagnosis? Biopsy of tumor

(Signed) Robert V. Clements, M. D.

.19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 11/24/1930

20 UNDERTAKER Wm Cook 127

ADDRESS St Paul st

0—M. & T.—100 B—50L

E 62577

E 62577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. ST., 14-26 WARD)

2-FULL NAME James L. Webb

(a) RESIDENCE NO. 2218 N. Pobleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unk yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	unknown

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	—	—	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) 870
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant David Carter

(Address) 916 Penna Ave.

Filed ... 1930 ... 193. ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Harluk, M. D. Coroner

Nov. 19 (Address) Hartline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 11-22-19

20 UNDERTAKER David Carter

ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

62578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 62578

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 939 N. Stricker St (Ward) 22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Banks

(a) RESIDENCE NO. 939 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of John Banks

6 DATE OF BIRTH (month, day, and year) Nov 20 1874

7 AGE: Years 56; Months 11; Days 25; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Montgomery Co. Md

(State or country)

PARENTS

10 NAME OF FATHER Alex Stewart

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant: Mary Warren

(Address) 939 N. Stricker St

15 Filed 12 1930

SAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6 1930, to Nov 20 1930,

that I last saw h.. alive on Nov. 18 1930,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach several months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? C. M. Pigott, M. D.

(Signed)

11/20 1930 (Address) 1536 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arbury Glen — Date of Burial 11-23 1930

20 UNDERTAKER: Jas. M. Steiner — ADDRESS 1621 E. Mad St

2 1930

1-30—M. & T.—100 B—50L

E 62579

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62579

CERTIFICATE OF DEATH

REGISTERED NO. 198

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ~~Enroute~~ Hopkins Hospital ST. 1-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leazer Shaver

(a) RESIDENCE NO 1013 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Checker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bugle Laundry

9 BIRTHPLACE (city or town) (State or country) Cumberland Co., Va

PARENTS

10 NAME OF FATHER George Shaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland Co., Va.

12 MAIDEN NAME OF MOTHER Ann Epps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Co., Va

14 Informant Jesse Shaver
(Address) 1013 N. Dallas

15 FILED 12 1930, 192 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage- stab wound of right Ventricle of heart

Homicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1721 E. Eager St

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. J. Gatton, M. D. Coroner

Nov. 21 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Farmville Va

DATE OF BURIAL Nov 23 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 130 Preston St

Spec.—1-30—M. & T.—250 Bks.

242836
62580

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62580

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME William Snyder

(a) RESIDENCE No. Martinsburg W. Va. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced (or) WIFE of unmarried

DATE OF BIRTH (month, day, and year) Jan 28 - 1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	25 24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) W. Va

10 NAME OF FATHER Samuel Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant JOHNS HOPKINS HOSPITAL Records
(Address)

Filed 2 1930, 19 JAMESON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-22-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930, to Nov 22, 1930, that I last saw him alive on Nov 22, 1930, and that death occurred, on the date stated above, at 3 00 A m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic hypertrophy, c urinary obstruction and retention of urine (duration) 5+ yrs. mos 1 da.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Conrad Acton, M. D.

11/22 1930 (Address) Johns Hopkins Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg W. Va.

DATE OF BURIAL Nov 24 1930

UNDERTAKER Geo. F. Smith

ADDRESS 1532 Hollins

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62581

114 E 62581

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 424 S. Augusta Ave ST. 70-24 WARD)

2-FULL NAME Frederick George Leuckert.

(a) RESIDENCE NO. 424 S. Augusta Ave ST. WARD (Irvington)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs mos ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower.

6 DATE OF BIRTH (month, day, and year) 4/20/1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63.	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C. W. Kenny Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Leuckert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Wilhimina Trauth.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Melton C. Leuckert.

(Address) 429 Gale Ave.

15 Filed 2 1930 C. HAMPSON JONES, M. D., Registrar, By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1930 to Nov. 19, 1930, that I last saw him alive on Nov 15, 1930, and that death occurred, on the date stated above, at 6.45 A.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(" Indigestion from Acid)

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Lloyd Johnson M. D.

19 (Address) 720 S. Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 11/22/30

20 UNDERTAKER Geo. A. Leimbach — ADDRESS 525 W. Lombard St

Spec.—1-30—M. & T.—250 Bks.

E 62582 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62582

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH South Balto. General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 21-24 ST. (WARD)

2-FULL NAME Franklin Mix Frank Mix

(a) RESIDENCE NO. 1153 Cleveland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced (HUSBAND) of (or) WIFE of Theresa Mix

DATE OF BIRTH (month, day, and year) June 14, 1860

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inside laborer

(b) General nature of industry, business, or establishment in which employed (or employer) machine shop.

(c) Name of employer Bartlett Heyward Co.

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Hospital Records (Address)

Filed 12-1, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1930, to Nov. 21, 1930, that I last saw him alive on Nov. 21, 1930, and that death occurred, on the date stated above, at 7 15 A m.

The CAUSE OF DEATH* was as follows:

Chronic cardiovascular renal disease

of unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) acute Cardiac dilatation

Central thrombosis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Joseph H. Laulcaitis M. D.

11/21/30 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Nov. 24 1930

20 UNDERTAKER [illegible] Cook

ADDRESS 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

E 62583

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 62583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33d + Calvert ST. 9-46 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Nannie Waddell

(a) RESIDENCE No. 733 E. 30th St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of ~~or Wife of~~ Mr Brandt Waddell

DATE OF BIRTH (month, day, and year) July 1, 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Westley Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Hachtler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hospital Records
(Address)

NOV 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930, to Nov. 21, 1930, that I last saw her alive on Nov. 21, 1930, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Pernicious anemia

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X-ray + Blood exam.

(Signed) Dr Francis W. Gluck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Abilene, Ga

DATE OF BURIAL 11/22 1930

UNDERTAKER William Cook

ADDRESS 1217 St Paul St

pec.—2-29-28—L. F. S.—500 Bks.

E 62584

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 62584

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 N. Patterson Park Ave. STATE. WARD) 6-10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME GEORGE B. TAYLOR

(a) RESIDENCE NO. 105 N. Patterson Park Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Taylor

DATE OF BIRTH (month, day, and year) Dec.17.1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deputy Registrar of Wills

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 28 years

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER James Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs. Margaret Taylor (Wife)

(Address) 105 N. Patterson Park Ave.

[illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930 to Nov 21, 1930, that I last saw him alive on Nov 21, 1930 and that death occurred, on the date stated above, at 4.05 a. m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo Chilton Blades, M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov. 24. 1930

20 UNDERTAKER Henry Sonder & Sons, Inc.

ADDRESS BALTIMORE ST & BROADWAY.

Dec.—2-29-28—1. F. S.—500 Bks.

E 62585

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62585

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 S. Curley ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CHARLES O. BISCOE

(a) RESIDENCE NO. 505 S. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of - - -

DATE OF BIRTH (month, day, and year) Dec. 13.1874

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	11	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Electrical Construction

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER William M. Biscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

Informant Miss Anna V. Biscoe

(Address) 505 S. Curley St.

Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1930, to Nov 20, 1930, that I last saw him alive on Nov 20, 1930, and that death occurred, on the date stated above, at 1.25 a. m.

The CAUSE OF DEATH* was as follows:

Endo carditis

Myo Carditis

Hy ... (duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Endo carditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart Lesions

(Signed) Dr. Mohr, M. D.

11-22, 1930 (Address) 3015 Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Nov. 24, 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

Spec.—2-29-28—L. F. S.—500 Bks.

E 62586

HEALTH DEPARTMENT—CITY OF BALTIMORE

00-001

E 62586

CERTIFICATE OF DEATH

1—PLACE OF DEATH Maryland General Hospital REGISTERED NO. 18-24

CITY OF BALTIMORE: (No. Linden Ave & Madison ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Dulski

(a) RESIDENCE NO. 395 S. Poppleton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 8, 1882

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	1	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER John Dulski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Josephine Zlonake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Sister Friend

(Address) 395 S. Poppleton

Filed 12 2 1930

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1930, to Nov 20, 1930,

that I last saw him alive on Nov 20, 1930

and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Peritonsillar Abscess

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Kenneth L. Berger M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov 24 1930
20 UNDERTAKER Chas B. Kuchaucka	ADDRESS 637 S Paca St

Spec.—1-30—M. & T.—250 Bks

E 62587 HEALTH DEPARTMENT—CITY OF BALTIMORE VE 62587

49

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Baltimore City Hospitals ST. 12-28 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.....

2-FULL NAME August Brown (Brauns)

(a) RESIDENCE NO. 214 S. Stricker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth

DATE OF BIRTH (month, day, and year) Mar. 4, 1864

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	8	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Records of

(Address) Balto. City Hosp.

C. HAMPSON JONES, M. D.

Filed 12 2 1930, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30

17 I HEREBY CERTIFY, That I attended deceased from 9-22-30, 19..., to 11-20-30 19...,

that I last saw him alive on 11-20-30, 19...,

and that death occurred, on the date stated above, at 7:10 PM

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) ...yrs. 5 mos ...ds.

CONTRIBUTORY (Secondary) Carcinoma of myocardium, metastatic (duration) ...yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Histology

(Signed) Paul Padgett M. D.

11-21, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Town Cemetery — DATE OF BURIAL Nov. 22nd 1930

20 UNDERTAKER Lilly + Zeiler Sons — ADDRESS 403 S. Wolfe St

pec.—1-30—M. & T.—250 Blks.

E 62588

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62588

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH In Home Hospital

CITY OF BALTIMORE: (No. Laurens & Eutaw ST., 8 WARD)

2-FULL NAME Addie Allen

(a) RESIDENCE NO. 2304 E Hoffman ST., WARD 22
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of the late Alex W. Nelson

DATE OF BIRTH (month, day, and year) May 1st 1863

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	6	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER George W. Garlin

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Brigit Donohue

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

Informant Thomas F. Nelson (Son)

(Address) 2304 E. Hoffman St.

Filed ..... 19 ..... Registrar

C. HAMPSON GIBBONS, M.D.

2-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 21. 30

17 I HEREBY CERTIFY, That I attended deceased from 11. 17. 30, 19..... to 11. 21. 30, 19.....

that I last saw h[illegible] alive on 11. 21. 30, 19.....

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Cancer Liver

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11/14/30

Was there an autopsy? No

What test confirmed diagnosis Operation

(Signed) J M Hundley M. D.

19 (Address) In Home Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 25th 1930
20 UNDERTAKER Lilly & Zeller Inc.	ADDRESS 403 S. Wolfe St

1-30—M. & T.—100 B—50L

E 62589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62589

8445

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3407 Lake Montebello ST., Drive WARD

2-FULL NAME T. Carroll Ford

(a) RESIDENCE NO 3407 Lake Montebello Drive ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of May E. Ford

6 DATE OF BIRTH (month, day, and year) May 4/1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	36	6	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Standard Oil Co

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas S. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Margaret B. McDermitt

13 BIRTHPLACE OF MOTHER Baltimore, Md.

14 Informant May E. Ford
(Address) 3407 Lake Montebello Drive

15 Filed NOV 22 1930, 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [signature] Coroner, M. D.

Nov 21/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Park Wood Cem.

DATE OF BURIAL Nov 24 1930

ADDRESS .....

20 UNDERTAKER Wm C Black 927 N Broadway

Spec.—1-30—M. & T.—250 Bks.

E 62590 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 62590

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1410 McElderry St. 5-9 WARD)

2-FULL NAME Clara M. Horsey Brown

(a) RESIDENCE NO. 1410 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Louis Brown

DATE OF BIRTH (month, day, and year) 1908

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
22	10		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto, Md

10 NAME OF FATHER Irvin Horsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bessie Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Bessie Horsey

(Address) 1410 McElderry St

Dec 22 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-30

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1930, to Nov. 20, 1930, that I last saw h[illegible] alive on Nov 19, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) yrs. unknown mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

11/20/30 (Address) 1424 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson's Cem.

DATE OF BURIAL 11-24 1930

UNDERTAKER Byrow Wright

ADDRESS 1218 McElderry St

Spec.—1-30—M. & T.—250 Bks

E 62591

E 62591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 1-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Lockes

(a) RESIDENCE NO. 22 So. Penn. Ave ST., Towson Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of James Lockes

DATE OF BIRTH (month, day, and year) 1889

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Richard Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nancy Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant James Lockes

(Address) 22 So. Penn. Ave Towson

Filed NOV 22 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 1930, 19..., to Nov 19, 1930, that I last saw h.r alive on Nov 19, 1930, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pelvic inflammatory disease

(Colon bacillus)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 1, 1930

Was there an autopsy? Yes Hysterectomy

What test confirmed diagnosis?

(Signed) Wylie M Law M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Rest Cem

DATE OF BURIAL 11-23 1930

UNDERTAKER Byron Wright

ADDRESS 1218 N. Eutaw St.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62592 E 62592

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2201 Maisel ST. 25-72 WARD

2-FULL NAME Maggie K. Schultheis

(a) RESIDENCE NO. 2201 Maisel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Schultheis

6b DATE OF BIRTH (month, day, and year): Dec 30 1860

7 AGE: Years 69 Months 11 Days 20

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Simon Segal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Lehmann

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant (Address): George Schultheis Catonsville Md.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930, to Nov 20, 1930, that I last saw h[illegible] alive on Nov 18, 1930, and that death occurred, on the date stated above, at 12:55 a.m.

The CAUSE OF DEATH* was as follows:

Pleurisis Abscess

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) Nov yrs. Nov mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Bacteria (B3)

(Signed) Rud Lantis, M. D.

(Address) 2208 Hadlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 11/22 1930

20 UNDERTAKER: Edw Foulon — ADDRESS: Work Blk

21 1930 G. HAMPSON JONES, M. D. Registrar

Rec'd

Spec.—1-30—M. & T.—250 Bks

E 62593 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62593

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (NO. 15-22 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Bowe

(a) RESIDENCE NO. 1363 N. Gilmor st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 24, 1911

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	5	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bootblack

(b) General nature of industry, business, or establishment in which employed (or employer) 056

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Fleming Bowe

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Isaac

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

Informant Hospital Records

(Address) UNIV

11-16 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to Nov. 16, 1930, that I last saw h. im alive on Nov. 16, 1930, and that death occurred, on the date stated above, at 10.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Pyopneumothorax

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Seuner, M. D.

11-16 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL NOV 21 1930

20 UNDERTAKER Commissioner Health.

ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 62594

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62594

CERTIFICATE OF DEATH

38

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals
CITY OF BALTIMORE: (NO. Potts St. (?) ST., 10-14 WARD)

2-FULL NAME Preston McCoy

(a) RESIDENCE NO. 713 N Central Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of —

DATE OF BIRTH (month, day, and year) 2-10-04

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
26		9	7	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ? 040
(c) Name of employer ?

BIRTHPLACE (city or town) Smithfield
(State or country) N.C.

10 NAME OF FATHER Preston McCoy ?

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Lilla Troy ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) N.C.

Informant Records
(Address) Baltimore City Hospitals

Filed 2 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-30

17 I HEREBY CERTIFY, That I attended deceased from 10-27- , 1930, to 11-17- , 1930, that I last saw him alive on 11-17- , 1930, and that death occurred, on the date stated above, at 6:30 p m.

The CAUSE OF DEATH* was as follows:

Aneurysm of Aortic Arch

(duration) yrs. mos ? ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

Acute (duration) ..... yrs. ..... mos. 20 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of 11-17-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Luther E. Little, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL NOV 21 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

By Wm. E. WEBSELL

1-30—M. & T.—100 B—50L

E 62595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62595

REGISTERED NO. 90 2743

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6506 Glenoak Ave ST., WARD)

2-FULL NAME Charles W. McCracken

(a) RESIDENCE NO 6506 Glenoak Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel McCracken

6 DATE OF BIRTH (month, day, and year) Sep 14/1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Metal Package Co

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo. McCracken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Dora Reinish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Louis McCracken

(Address) Mason & Joppa, Carney, Md.

15 Date Nov 22 1930, 192 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency-Probably—Valvular

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Mullen, Coroner, M. D.

Nov 22/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakdale Cemetery

DATE OF BURIAL Nov 24 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62596

90 E 62596

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 200 E. Federal St., 12-19 Ward)

2-FULL NAME Calvin T Houston

(a) RESIDENCE NO. 200 E. Jefsal St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 29, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Bethelhem
(c) Name of employer Steel Co.

9 BIRTHPLACE (city or town) N.C.
(State or country)

PARENTS

10 NAME OF FATHER Bernie Houston

11 BIRTHPLACE OF FATHER (city or town) N.C.
(State or country)

12 MAIDEN NAME OF MOTHER Alice Long

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.C.

14 Informant Mary Houston
(Address) 200 E. Federal st

15 Filed 19 J. HARRISON JONES, Registrar

21930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Callen, M. D.

Nov 22/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Davidson N. C.

DATE OF BURIAL Nov. 23 1930

20 UNDERTAKER Mrs. P. G. Elliott

ADDRESS 1725 Ashland Ave

Spec.—1-30—M. & T.—250 Bks

E 62597 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62597

46

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospitals 12-19 WARD)

2-FULL NAME Cornelia Prophet

(a) RESIDENCE NO. 427 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of ?

DATE OF BIRTH (month, day, and year) Unknown.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	?	?	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Gen

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Paul Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Virginia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Burdon

(Address) Balto City Hosp

Filed 12 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-19-30

17 I HEREBY CERTIFY, That I attended deceased from 11-13, 19 30, to 11-19, 19 30, that I last saw h[illegible] alive on 11-19, 19 30, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix of Uterus

? (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Luther E Leitch, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Drake Branch Va

DATE OF BURIAL Nov. 23 19 30

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Ashland Ave

pec.—1-30—M. & T.—250 Bks.

E 62598 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62598

CERTIFICATE OF DEATH.

REGISTERED NO. 654

1-PLACE OF DEATH Church Home + Infirmary

CITY OF BALTIMORE: (No. North Broadway ST. 65 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Tilghman

(a) RESIDENCE NO. New Castle, Del. ST., WARD New Castle, Del.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 47 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed or divorced HUSBAND of or) WIFE of Summerfield Tilghman

DATE OF BIRTH (month, day, and year) 1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Lloyd D Tilghman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Edward Emory

(Address) Roanoke Va

Filed 2-3 1930 H. MARION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-30

17 I HEREBY CERTIFY, That I attended deceased from 10-6, 1930, to 11-22, 1930, that I last saw h[illegible] alive on 11-22-, 1930, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Pyelitis; Perineal Abscess, left (duration) yrs. mos. 4 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 11-6, 8, 15, 17, 1930

Was there an autopsy? Partial Examination

What test confirmed diagnosis? Autopsy + Blood Chemistry

(Signed) Vernon H. Norwood, M. D.

, 19 (Address) Church Home Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Centreville Md	Feb 3, 1930
20 UNDERTAKER John A Mitchell & Son	ADDRESS Baltimore Md

pec.—1-30—M. & T.—250 Bks.

42825
E 62599

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62599

CERTIFICATE OF DEATH.

REGISTERED NO. 70

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

2-FULL NAME Gloria Meyers

(a) RESIDENCE NO. 3 Farrington St ST., WARD Caldwell N J

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) September

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	X			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N-J-

10 NAME OF FATHER Emanuel Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Bell Belloyitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

Informant JOHNS HOPKINS HOSPITAL Records
(Address)

Filed 1930 C. HARRISON JONES, M. D.
Registrar

Page

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22-30

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1930, to Nov. 02, 1930,

that I last saw her alive on Nov. 22, 1930,

and that death occurred, on the date stated above, at 3 25 P m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-21-30

Was there an autopsy? yes Abscess drained

What test confirmed diagnosis? C M

(Signed) Judd Gelb, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark N J

DATE OF BURIAL 11/23/30

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

E 62600

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 62600

CERTIFICATE OF DEATH

REGISTERED NO. 16-68

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2833 Riggs Ave. ST. WARD)

2—FULL NAME Laura V. Metz,

(a) RESIDENCE NO. 2833 Riggs Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

DATE OF BIRTH (month, day, and year) March 17. 1858

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	8	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER John F. Metz,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Parker,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Mrs Cora Wilburn

(Address) New York

Filed ..... 19 ..... Registrar

231930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1930, to Nov 22, 1930,

that I last saw h[illegible] alive on Nov 9, 1930,

and that death occurred, on the date stated above, at 11 40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. R. Keen, M. D.

11/22, 1930 (Address) 3911 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL NOV 24 1930

20 UNDERTAKER Geo D Settle

ADDRESS 2700 EDMONDSON AVE.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62601 — 90 E 62601

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 16-68 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Richard Rotan

(a) RESIDENCE NO. 2536 W. Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Rotan

DATE OF BIRTH (month, day, and year) June 1, 1841

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	5	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 0.50

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of

(Address) Balto. City Hosp.

Filed 2/3 1930, 19 RLK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21-30

17 I HEREBY CERTIFY, That I attended deceased from 5-20-30, 19, to 11-21-30, 19, that I last saw him alive on 11-21-30, 19, and that death occurred, on the date stated above, at 2:20 P m.

The CAUSE OF DEATH* was as follows:

Heart disease, arteriosclerotic

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Town 2. Hospital

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Paget. M. D.

11-22, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 11/24/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St. Paul st.

Rec. 2-29-28—1. F. S.—500 Bks.

E 62602

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002 E 62602

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 120 S. Curley ST. 1-2 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant Schnitzler

(a) RESIDENCE NO. 120 S. Curley ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX male | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 22-30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				20

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Rudolph H. Schnitzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ida Sophia Limburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Rudolph Schnitzler

(Address) 120 S Curley

Filed 2-3 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22-30

17 I HEREBY CERTIFY, That I attended deceased from 11-22 1930 to 11-22 1930

that I last saw him alive on 11-22 1930

and that death occurred, on the date stated above, at 4 20 A m.

The CAUSE OF DEATH* was as follows:-

Asphyxia (Infant)
Umbilical Cord Around
Neck

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cook M. D.

11/22 19 30 (Address) 1 S Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 11/24 1930

20 UNDERTAKER m Cook

ADDRESS 1217 St Paul st

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62603

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. E 62603

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital, St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rita Balcer,

(a) RESIDENCE NO. 429 S. Bond St., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27, 1930

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Charles Balcer,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Olszewski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Josephine Balcer,

(Address) 429 S. Bond St.,

15 Filed 23 1930 C. Hubert Jones M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia- Enlarged Abdominal Lymph Glands

(AutOpsy at Hopkins)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(signed) J. C. Hubert M. D.

(Coroner)

Nov 22 1930

(Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial Nov. 24 1930

20 UNDERTAKER John M. Weber ADDRESS 402 Chester

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 E 62604

62604

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 4803 Braden Ave. (ST.) 27-56 (WARD)

2-FULL NAME Helen Thiman

(a) RESIDENCE NO. 4803 Braden Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Harry Braden

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bucto, Ind

10 NAME OF FATHER Isaac Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant J. Lewis

(Address) 1439 Eutaw Pl.

File No. 231938 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1928, to Nov. 22, 1930, that I last saw her alive on Nov. 22, 1930, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with metastases

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec. 1, 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab. & X-Ray

(Signed) Isidor L. Levy, M. D.

Nov. 1930 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 11-23-1930

20 UNDERTAKER Jacob Lewis, 1439

ADDRESS Eutaw St

Spec.—1-30—M. & T.—250 Bks

E 62605 ✓ E 62605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N. Ann ST. 6-9 WARD)

2-FULL NAME Bessie Shochet

(a) RESIDENCE NO. 121 N. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mordecai Shochet

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant J. Lewis

(Address) 1439 E Balto St

Filed 1 23 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20 1930 to Nov. 22 1930,

that I last saw h[er] alive on Nov. 21st 1930,

and that death occurred, on the date stated above, at 12 15 A. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal Disease

(Hypertrophy, Arteriosclerosis, Chronic Nephritis)

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam & Laboratory

(Signed) A. T. Ellis, M. D.

Nov 22 1930 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bath Israeth, Windsor Mill Rd — DATE OF BURIAL 11-23-1930

20 UNDERTAKER Jacob Lewis, 1439 E Balto — ADDRESS

Spec.—1-30—M. & T.—250 Bks.

62606

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62606

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 15 N Kresson ST. 16-37 WARD

2-FULL NAME Thomas Hankinson

(a) RESIDENCE NO. 15 N Kresson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Annie Hankinson

DATE OF BIRTH (month, day, and year) May 22-1854

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	76	5	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer) retired 1 86

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Mrs. Lou Bregle

(Address) 15 N Kresson ave

Filed 23 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 14" , 1930, to Nov. 21' , 1930,

that I last saw h[illegible] alive on Nov. 20' , 1930,

and that death occurred, on the date stated above, at 12 43 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 9 mos 7 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) Isabel H. Ritter, M. D.

Nov 22, 1930 (Address) 100 E Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Nov 24, 30

20 UNDERTAKER John Leech

ADDRESS Baltimore

1-30—M. & T.—100 B—50L

E 62607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 E 62607

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hopkins Hospital ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Voelker

(a) RESIDENCE NO 900 Rutland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	2 3	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Telegraph Operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Voelker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Lemke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. John Ebersberger
(Address) 1913 E. 32nd St

15 Filed 2-3-1930, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death hrs on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage & Laceration
Bullet wound left temple.
Probably Suicide.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 900 Rutland Ave

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [signature], Coroner, M. D.

11/22/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Nov 24 1930

20 UNDERTAKER John Merrick

ADDRESS 400 Orleans

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62608

CERTIFICATE OF DEATH

129 E 62608

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 Linwood. St. Ave. WARD) 11th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George M. France

(a) RESIDENCE NO. 742 N. Linwood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. France

DATE OF BIRTH (month, day, and year) Feb. 8-1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Self. Chance

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER James France

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Md.

12 MAIDEN NAME OF MOTHER Catherine Webster

13 BIRTHPLACE OF MOTHER (city or town) Deal's Island. (State or country) Md.

Informant Laura V. France

(Address) 742 N. Linwood Ave

Filed Nov 29 1930 C. HARRISON JONES, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22-1930

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1930, to November 22, 1930, that I last saw he was alive on Nov 22, 1930, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease (Nephritis)
Uraemia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Nov 23, 1930 (Address) 2431 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Deal's Island. Md. DATE OF BURIAL: Nov. 24 1930

20 UNDERTAKER: Hughes & Sons Inc ADDRESS: 424 N. Broadway

Spec.—1-30—M. & T.—250 Bks

E 62609 ✓ E 62609

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 14-20 ST. ..... WARD)

2-FULL NAME Edward Maynard

(a) RESIDENCE NO. 2025 Madison Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) April 30, 1887

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	6	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer Chateau Hotel

BIRTHPLACE (city or town) (State or country) West Indies

10 NAME OF FATHER Jacob

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Rebecca Turpin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies

Informant (Address) Records of Balto. City Hosp.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21-30

17 I HEREBY CERTIFY, That I attended deceased from 10-29-30, 19 ..... to 11-21-30, 19 ....., that I last saw him alive on 11-21-30, 19 ....., and that death occurred, on the date stated above, at 6:40 A.m.

The CAUSE OF DEATH* was as follows:

Syphilis, Tertiary
Luetic Aortitis & Aortic Insufficiency
Myocarditis Chronic
more than (duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted, if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. Glenn Jr. M. D.

19 ..... 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Nov. 24, 30

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pheasant St

2 31930 ..... 19 ..... Registrar

pec.—1-30—M. & T.—250 Bks.

242682

E 62610

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62610

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 (WARD)

2-FULL NAME Charles Meily

(a) RESIDENCE NO. Palmyra Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Unknown.

DATE OF BIRTH (month, day, and year) Sept-18-1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	2	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stocks & Bonds

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Emily Pinkerton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed 12-3 1930. 19 ROY Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Nov 22, 1930, that I last saw him alive on Nov 22, 1930, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) H Ober Dietticker, M. D.

11-23 19 30 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisburg Penna

DATE OF BURIAL 11/23 1930

20 UNDERTAKER Urlaim Cook

ADDRESS 141 St Paul

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62611

CERTIFICATE OF DEATH

90 V

E 62611

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2163 Hollins ST. 2518 Hobb WARD 70-69)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Minnie K Hess

(a) RESIDENCE NO 2163 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Hess

6 DATE OF BIRTH (month, day, and year) May 5, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work W. H
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maggie McKee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John A Hess

(Address) 2163 S Hollins

15 Filed . G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas W Brooke, M. D. Coroner

Nov 23, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Accompanied

DATE OF BURIAL 11/25 1930

20 UNDERTAKER Wilson Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

E 62612

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62612

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH
CITY OF BALTIMORE (No. 1211 Eutaw Place ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Baker Walters

(a) RESIDENCE NO. 1211 Eutaw Place ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Edward

DATE OF BIRTH (month, day, and year) May 22, 1862

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	9		

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Henry Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. E. Meisley
(Address) 1211 Eutaw Place

Filed 11/24/1930 HALLAM JONES, M. D. Registrar

241936

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 22 1930, to Nov 22nd 1930, that I last saw h[illegible] alive on Nov 22nd 1930 and that death occurred, on the date stated above, at 5.30 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
& Decompensation
7 ?
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edward Walters
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Wood M. D.

11/23, 1930 (Address) 1211 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 11/24/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

E 62613

E 62613 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ST. 5-8 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas McKay.

(a) RESIDENCE No. 905 Necessity Alley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Mar. 9, 1868

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	8	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Shoer. Op

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER David McKay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Sarah Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Records of. (Address) BALTIMORE CITY HOSPITALS

Filed 24 1930 G. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1930, to Nov. 22, 1930, that I last saw h alive on Nov. 22, 1930, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 1 Home 2 Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Paget, M. D.

1-23 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Harford Rd) Cemetery — DATE OF BURIAL 11/25/1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

Spec. 1-10-21 MAT 1500 Blks.

E 62614

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62614

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1712 Lamont Ave (St.) (Ward) 9-18

2-FULL NAME Florence McGregor

(a) RESIDENCE No. 811 Aisquith St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 17th 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
56	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleswoman

(b) General nature of industry, business, or establishment in which employed (or employer): Dept Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joseph McGregor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Emma Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Charles R. Elliott

(Address): 1712 Lamont Ave

15 [illegible]

Registrar: HAMPSON JONES, M. D.

241930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/22/30 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Nov 22, 1930,

that I last saw her alive on 11/22, 1930,

and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(duration) yrs 3 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Xray

(Signed) [illegible] M. D.

11/23 1930 (Address) 701 Edwards

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetary — DATE OF BURIAL: 11/25/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62615

E 62615

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. St Agnes Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Margaret Jones

(a) RESIDENCE NO. 1 Gibson Boston St. Ward Rustown Rd Granby Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmale	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm Jones

6 DATE OF BIRTH (month, day, and year) Feb 16 885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	9	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 14 40 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Va.

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Wm Randall

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Husband
(Address)

15 Filed 19 Registrar

241930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Peritonitis following abortion Self induced

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Brooke M. D.

Nov 22, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL Nov 24 1930

20 UNDERTAKER Schumacher & Son — ADDRESS 2105 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

Lance H. Helmling

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

188-103

E 62616

E 62616

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Lan Jn. Hos St., No 42 Ward)

2-FULL NAME Lance H. Helmling

(a) RESIDENCE NO. 4782 Hazelwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 - 1921

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	9	5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Milton C Helmling

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Kath M Schaaf

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Katharine M Helmling
(Address) 4782 Hazelwood ave.

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21 192 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & knocked down by auto as he ran into its path.

@ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wheeler Rd Balto Co

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Fraser, M. D.

11-22-1930 (Address) 2929 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lowden Park Cemetery — DATE OF BURIAL Nov 24 1930

20 UNDERTAKER George W Zirkler — ADDRESS 1737 E Lex

Spec.—1-30—M. & T.—250 Bks.

E 62617

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62617

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Anthus McInnes 16-22 WARD)

2-FULL NAME 1241 Whatcroft St.

(a) RESIDENCE NO. 1241 Whatcroft ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Eva McQueen.

DATE OF BIRTH (month, day, and year) 1890

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Public

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Co.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Eva McQueen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md.

Informant Wm H. Queen

(Address) 1241 Whatcroft St

Filed 1930 C. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/21/1930

17 I HEREBY CERTIFY, That I attended deceased from 11/19/30, 19..., to 11/21/30, 1930.

that I last saw h... alive on 11/21/30,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

(Address) 924 Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dust Antrim

DATE OF BURIAL 11-24-30

20 UNDERTAKER Daniel Corbin

ADDRESS 910 Pa Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 62618

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62618

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 E. Lee ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa Fr. Whitaker

(a) RESIDENCE NO. 1213 E. Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Frank H. Whitaker

DATE OF BIRTH (month, day, and year) Aug 14 1854

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	6	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Elizabeth M. Whitaker

(Address) 1213 E. Lee St.

Filed NOV 24 1930 LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1930, to Nov. 23, 1930, that I last saw h[illegible] alive on Nov 22, 1930 and that death occurred, on the date stated above, at 4 20 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

not definite

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hopkins, M. D.

11/24, 1930 (Address) 124 N. Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eastwood Cem	12-26 1930
20 UNDERTAKER Edward J. Rank	ADDRESS 642 S. Stre[illegible]

pec.—1-30—M. & T.—250 Bks.

E 62619

62619 HEALTH DEPARTMENT—CITY OF BALTIMORE 167-002

CERTIFICATE OF DEATH. REGISTERED NO. 27453

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6 Church Home & Infirmary (Ward)

2-FULL NAME Baby Girl McKenzie

(a) RESIDENCE NO. 6 Church Home & Infirmary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 11-22-30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	1 day	6

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER James Brown McKenzie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Leah Bertha Burkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisville, Md

Informant Leah B. McKenzie (Mother)

(Address) 1819 Woodland ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-30

17 I HEREBY CERTIFY, That I attended deceased from 11-22, 1930, to 11-23, 1930,

that I last saw her alive on 11-23, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in utero

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? post mortem

(Signed) Asa E. Hubbard, M. D.

11-24, 1930 (Address) 409 Cornwall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Nov 24 1930

20 UNDERTAKER Edward D. Mitchell

ADDRESS 1200 Eutaw Place

Filed 11-24 1930 C. HAMPSON JONES, M. D. Registrar

Spec.—I-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62620

CERTIFICATE OF DEATH.

31

E 62620

1-PLACE OF DEATH 2210 E. North ave

CITY OF BALTIMORE: (No. 2210 E. North Ave ST., 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel H. Smith

(a) RESIDENCE NO. 2210 E. North Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

If married, widowed, or divorced HUSBAND of or) WIFE of Pearl G.

DATE OF BIRTH (month, day, and year) Aug 22 1879

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51	51	2	30	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Samuel H.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Eliza Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Mrs John Frith

(Address) 2210 E. North Ave.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930, to Nov 21, 1930, that I last saw h. alive on Nov 20, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Laryngeal tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Laryngeal tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Geo H Adler, M. D.

11-21 1930 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	11-24 1930
UNDERTAKER	ADDRESS
Jack Lewis	1937 E. Baltos.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62621 — REGISTERED NO. E 62621

101-001

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General Hospital (ST.) (WARD) 93-30

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Mary E. Crowley.

(a) RESIDENCE No. 49 E. Heath St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 4 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (Of) WIFE OF Albert M. Crowley.

6 DATE OF BIRTH (month, day, and year) July 5, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Luke McLaughlin.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Katherine Casey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Albert M. Crowley. (husband)
(Address) 49 E. Heath St.

15 Filed 12-1930 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) November 20, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 49 E. Heath St.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Ole M. Hernandy, M. D. Coroner

11/20/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Nov. 24 1930

20 UNDERTAKER Margaret E. Flynn — ADDRESS 14 W. Eight St.

Cor.—10-10-29—A Co.—100 Bks.

62622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 38

REGISTERED NO. E 62622

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp. 9-9 Ward)

2-FULL NAME Stella May Jackson

(a) RESIDENCE NO. Back River Road Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	C.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12 1930

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Back River
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Estella Williams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Estella Williams
(Address) Back River Md.

15 Filed ..., 19.. HARRY S. GRIES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Syphillis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Nov. 24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	Nov. 24 1930
20 UNDERTAKER Mrs R. G. Elliott	ADDRESS 1725 Ashland Ave

Spec.—1-12-23—M&T—500 Bks.

E 62623

HEALTH DEPARTMENT—CITY OF BALTIMORE E 62623

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1834 W. Fayette St. ST. 19-27 WARD)

2-FULL NAME Anna Sullivan

(a) RESIDENCE NO. 1834 W. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of John P. Sullivan

DATE OF BIRTH (month, day, and year) Oct. 10, 1872

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	1	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Jeremiah Maguire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Monahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mr. John P. Sullivan

(Address) 1834 W. Fayette St.

Filed 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from November 22, 1928, to November 22, 1930.

that I last saw her alive on November 22, 1930.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw Mendelsohn M. D.

11/24 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 11/25 19 30

20 UNDERTAKER John J. Coyan & Son 201 Rolling Rd.

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62624

CERTIFICATE OF DEATH

E 62624

REGISTERED NO. 101-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hosp. Ward) 37-55

2-FULL NAME Carl Jelenko 3rd

(a) RESIDENCE NO. 3317 Toney Road Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 9, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Carl Jelenko, Jr.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Helen T. Simpson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Tennessee

14 Informant Carl Jelenko, Jr.
(Address) 3317 Toney Rd.

1930 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Retro-phraryngeal abcess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 23/30

Was there an autopsy? no Tracheotomy

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Nov 24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cem.

DATE OF BURIAL 11/24/30

20 UNDERTAKER David Sondheimer Son

ADDRESS 1702 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Bks.

E 62625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 V E 62625

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3108 Ruckert ST. 77-44 WARD)

2—FULL NAME Andrew J. Durall

(a) RESIDENCE NO. 3108 Ruckert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
WIFE of (or) HUSBAND of Maria L. B. Durall

DATE OF BIRTH (month, day, and year) July 12th 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R R

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Andrew J. Durall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mollie Jerdon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs Maria L B Durall (wife)

Address 3108 Ruckert St

Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 21-1930

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to November 21, 1930, that I last saw him alive on Nov 20, 1930, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia 3 days
Myocarditis Decompensatio 20 mos
Adult Selerosis - Hypertension

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis

(duration) 1 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Thos F. A. Stevens, M. D.

11/21, 1930 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL Nov 25 1930

20 UNDERTAKER Harriet Lyter — ADDRESS 1600 N Monroe

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62626

E 62626

CERTIFICATE OF DEATH.

REGISTERED NO. E 62626

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Chauncey Ave., ST., 13-59 WARD)

2-FULL NAME Israel Finz

(a) RESIDENCE NO. 814 Chauncey Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Single~~ Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Minna Finz

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant I. Lewis, 1433 E. Balto. St.

(Address)

Filed 12-2, 1930 H. H. JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23-30

I HEREBY CERTIFY, That I attended deceased from 11-20, 1930, to 11-20, 1930, that I last saw him alive on 11-20, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endo Carditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Vascular

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Freedberg M. D.

11/24/1930 (Address) 918 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew

DATE OF BURIAL 11-24-1930

20 UNDERTAKER Jack Lewis, 1439

ADDRESS E. Balto St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 62627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 62627

1—PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Rose Stubinsky

(a) RESIDENCE NO. 3729 Lawanda Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Stubinsky

DATE OF BIRTH (month, day, and year)

AGE: Years 47; Months; Days; If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: David ~~Stubinsky~~

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Lillian ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: J. Lewis

(Address): 1439 E Balto St

NOV 24 1930 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1930, to Nov 24, 1930

that I last saw her alive on Nov 24, 1930

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

1. Chronic valvular heart disease (mitral stenosis) Auricular fibrillation
2. Cerebral embolism

(duration) unknown mos. ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of?

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Ashman, M. D.

19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: 11-24-30

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto

Spec.—1-12-23—M&T—500 Bks.

E 62628

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 62628

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH Lemdale - Hebrew Home (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. For Aged ST. 47-34 WARD)

2-FULL NAME Jacob Shapiro

(a) RESIDENCE NO. Lemdale ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Shapiro

DATE OF BIRTH (month, day, and year)

AGE Years 91 Months Days If LESS than 1 day, hrs or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Sigmund Shubbard
(Address) Belvedere & Greenspring

24 1930 THAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-9, 1930, to 11-24, 1930,

that I last saw him alive on 11-24, 1930

and that death occurred, on the date stated above, at 12.45 A m

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W Edmund Harris, M. D.

, 19 (Address) Lemdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Sholom

DATE OF BURIAL 11-24 1930

20 UNDERTAKER Jack Lewis, 1439 E Balto.

ADDRESS

Spec.—9-30—A. & Co.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62629

CERTIFICATE OF DEATH.

129 E 62629

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2411 Forest Park Ave. ST. 15-60 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John William Holsinger

(a) RESIDENCE NO. 2411 Forest Park Ave ST. 28 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie E. Holsinger

6 DATE OF BIRTH (month, day, and year) March 27, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Alexander Holsinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jane Mongold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

PARENTS

14 Informant Mrs. Minnie E. Holsinger

(Address) 2411 Forest Park Ave.

15 24 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1930.

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to Nov 22, 1930

that I last saw him alive on Nov 22, 1930

and that death occurred, on the date stated above, at 10.40 A.m.

The CAUSE OF DEATH* was as follows:

Nephritis and Uraemic Poisoning

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 3 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. C. Everhart, M. D.

11/23, 1930 (Address) Woodlawn P.O.

*State the Disease Causing Death, or in deaths from Violence state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL via B.&O.R.R. Timberville, Va.

DATE OF BURIAL Nov. 25 1930

20 UNDERTAKER John L. Denney

ADDRESS 715 Eight St.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62630

CERTIFICATE OF DEATH.

129

E 62630

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Orkney Road, ST., 27-48 WARD)

2-FULL NAME Carroll I. Way.

(a) RESIDENCE NO. 500 Orkney Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 18th. 1877

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	11	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer Stationary

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER John H. Way

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Rose A. Reilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs. Wm. J. Maher.

(Address) 500 Orkney Road; Govans.

Filed 12-1-1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22nd. 1930

17 I HEREBY CERTIFY, That I attended deceased from January, 1924 to Nov 22, 1930.

that I last saw him alive on Nov 22, 1930.

and that death occurred, on the date stated above, at 2.25 P m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. mos 6½ hours ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam + Urinalysis

(Signed) Thos. R. Geraghty M. D.

11/22, 1930 (Address) 2225 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL Nov. 25 19 30

ADDRESS

20 UNDERTAKER Chas. R. Kraus & Son 1811 Mt. Royal ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62631

CERTIFICATE OF DEATH

74-001

E 62631

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 S. Montford Ave ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanislaus Minchkowski

(a) RESIDENCE NO. 727 S. Montford Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Jan. 27 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	74	9	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

Informant Lawerence Minchkowski

(Address) 633 S. Montford Ave.

Filed 24 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1930 to Nov 22 1930

that I last saw him alive on Nov 22 1930

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 22 mos. dy.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Dawson M. D.

19 33 (Address) 600 N Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Stanislaus Cem.	Nov. 25 1930
20 UNDERTAKER	ADDRESS
Stephen J. Trabkowski	1000 S. Kenwood Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62632 | 31 | E 62632

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2662 Lanette Ave ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Marie Bradshaw

(a) RESIDENCE NO. 2662 Lanette Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ✓ mos. ✓ ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 14, 1908

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	9	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Deal's Island Somerset Co. Md.

10 NAME OF FATHER Bayfield Frank Bradshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Marion Station Maryland

12 MAIDEN NAME OF MOTHER Neva Benton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Deal's Island Maryland

Informant Josephine Eliz. Peters

(Address) 2662 Lanette Ave

Filed 4 1930 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1930, to Nov 22, 1930.

that I last saw h.. alive on Nov 22, 1930

and that death occurred, on the date stated above, at 7.15 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings Lab. Wasserm

(Signed) , M. D.

, 19 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery. DATE OF BURIAL Nov. 25th 1930.

20 UNDERTAKER Charles J. Schwab. ADDRESS 505 N. Monroe St.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62633 — REGISTERED NO. E 62633

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 W Baltimore St. 18-76 WARD)

2-FULL NAME Frank I Bauer

(a) RESIDENCE NO. 1827 W Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 4 1879

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51		18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Theodore H Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

Informant Miss Mary Bauer

(Address) 1827 W Baltimore

Filed Nov 24 1930 C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22/30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1929, to Nov. 22, 1930, that I last saw him alive on Nov. 21, 1929, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation Jet

(Signed) J M Dellett M. D.

Nov. 24, 1930 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/25 1930
20 UNDERTAKER George A Fahey	ADDRESS Fulton & Forsythe

pec.—1-30—M. & T.—250 Bks.

E 62634

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62634

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., 9-17 WARD)

2-FULL NAME Virginia Miles

(a) RESIDENCE NO. Havre de Grace Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 15 1925

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	9	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland.

10 NAME OF FATHER Paul J. Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

Informant Paul J. Miles

(Address) Havre de Grace Md

Filed 4 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-22-30, 19..., to 11-24-30, 19...,

that I last saw h- alive on 11-24-30, 19...,

and that death occurred, on the date stated above, at 3,50 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings

(Signed) Lawrence G. Shreve, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace Md — DATE OF BURIAL 11-25 1930

20 UNDERTAKER J A Brannington Son — ADDRESS Havre de Grace Md.

Spec.—1-30—M. & T.—250 Bks.

E 62635 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62635

+ 100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Williams

(a) RESIDENCE No. 2401 Eastside Ave ST., WARD Amannati-Ohio
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Emma Williams

DATE OF BIRTH (month, day, and year) Mar. 8-1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	8	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance President

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer Western & Southern Insurance Co.

BIRTHPLACE (City or town) Cincinnati (State or country) Ohio

10 NAME OF FATHER Wm J. Williams

11 BIRTHPLACE OF FATHER (city or town) New York (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary Hanoran

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 27, 1930, that I last saw him alive on Nov. 24, 1930, and that death occurred, on the date stated above, at 9 40 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Myocardial Failure

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/21/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. C. Smith, M. D.

19 11/24 30 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cincinnati, Ohio

DATE OF BURIAL Nov. 24th 1930

20 UNDERTAKER Joseph Hook

ADDRESS 1003 West Baltimore St.

4 1930

pec.—1-30—M. & T.—250 Blks.

E 62636 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 62636

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Cronin

(a) RESIDENCE NO. 1013 Wilcox ST., ST WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 11/15/30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7 9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md —

10 NAME OF FATHER Bernard Cronin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Catherine Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

Informant Friends.

(Address)

Filed 4 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1930, to Nov. 24, 1930, that I last saw him alive on Nov. 24, 1930, and that death occurred, on the date stated above, at 7 45 a m.

The CAUSE OF DEATH* was as follows:

Tetanus neonatorum

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

11/24, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Ground — DATE OF BURIAL: Nov 26 1930

20 UNDERTAKER: Edward W. Corbin — ADDRESS: 924 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-01 ✓

E 62637

E 62637

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 11-24 WARD)

2—FULL NAME Baby Boy Guzik Rosemont Md.

(a) RESIDENCE NO. Lorraine Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	American	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 21, 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... mm.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Miss Berina Juzik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Hospital records

(Address)

Filed ... 1930 ... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930, to Nov 22, 1930,

that I last saw him alive on Nov 22, 1930

and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Immaturity (7 mnths)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert V. Clements, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

NOV 24 1930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62638 E 62638

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 712 W Ramsey St (St.) 21-29 (Ward)

2-FULL NAME Annie Hausman

(a) RESIDENCE No. 712 Ramsey St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life time How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1860

7 AGE Years 70 Months 6 Days — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 69

(b) General nature of industry, business, or establishment in which employed (or employer) Dress maker

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. City Md

10 NAME OF FATHER Geo Hausman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City

14 Informant Mrs Dora Hausman

(Address) 712 Ramsey St

Filed 4 1930 C. HAMPSON JONES, M.D. Registrar

Per ASH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15 1930 to Nov 22 1930, that I last saw her alive on Nov 21 1930 and that death occurred, on the date stated above, at 10 am

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cardiac Dilatation (duration) yrs mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M B Finlinger, M.D.

11/24 1930 (Address) 712 W Ramsey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 11/25/30

20 UNDERTAKER Geo Lambert & Sons — ADDRESS Reisterstown Md

Spec—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62639

E 62639

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1106 Canal ST. 21-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edwin Manyold

(a) RESIDENCE NO. 1106 Canal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) May 26/30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Wm Manyold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pauline Previt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Wm Manyold

(Address) 1106 Canal St

Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 14. to Nov 22 19 30.

that I last saw him alive on Nov 22 19 30.

and that death occurred, on the date stated above, at 10 34 p.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Mac Murchy M. D.

, 19 (Address) 1471 Hanford Rd

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL 11/25/30

20 UNDERTAKER Geo Leimbach 520 N Eutaw St

Spec.—1-30—M. & T.—250 Blks

E 62640

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62640

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH University Hospital 2-28 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Daisy Keller.

(a) RESIDENCE NO. 1123 Bayard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem'l	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of child

DATE OF BIRTH (month, day, and year) May 6 1924

AGE	Years	Months	Days	If LESS than 1 day, ... hr. or ... min.
	6.	6	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Cambridge Md

10 NAME OF FATHER Emory Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sykesville Md

12 MAIDEN NAME OF MOTHER Louise Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

Informant Emory Keller

(Address) 1123 Bayard St.

NOV 24 1930 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1930, to Nov 23, 1930, that I last saw her alive on Nov 23, 1930, and that death occurred, on the date stated above, at 6.02 A. m.

The CAUSE OF DEATH* was as follows:

Third degree burns of body and bowel intestinals (Burns)

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia.

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George J. Snoops Jr., M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL 11/25/30

UNDERTAKER Geo Kemble

ADDRESS 29 N Eutaw St

Dec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 62641

E 62641

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Lanvelton ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jas. Edmonds

(a) RESIDENCE NO. 1002 Lanvelton ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Mal	col	Single

If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 14 1911

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	19	3	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work scholar

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Chas. Edmonds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Wrayshell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Thomas Edmonds

(Address) 1022 Lanvelton Ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1930, to Nov 22, 1930

that I last saw him alive on Nov 22, 1930

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank E. Wagner M. D.

11/26 1930 (Address) 625 Schroeder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenbridge, Va.

DATE OF BURIAL 11/25/1930

20 UNDERTAKER Mrs Geo. E. Holland

ADDRESS 1631 Druid Hill Ave

pec.—1-30—M. & T.—250 Bks

E 62642 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 125 E 62642

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4-7 WARD)

2-FULL NAME Albert Will.

(a) RESIDENCE NO. Woodbine Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married.

If married, widowed, or divorced HUSBAND of or) WIFE of Mary Catherine Will

DATE OF BIRTH (month, day and year) 1881. no family record

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	yrs			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER William Will.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederick Hartzman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Estelle H. Hill

(Address) R.F.D. Woodbine, Md.

Rec'd ... 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24/30.

17 I HEREBY CERTIFY, That I attended deceased from 11/17, 1930, to 11/24, 1930;

that I last saw him alive on 11/24, 1930,

and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Pancreatitis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 5 hrs

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Sept. 1930.

Was there an autopsy? yes.

What test confirmed diagnosis? Laparotomy

(Signed) G. Brown Mandorfer M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mercy Cem. Messiah Cemetery	Nov 27-1930.
20 UNDERTAKER	ADDRESS
C. M. Watts	Ilchfield, Md.

Spec.—9-30—A. & Co.—250 Bks.

Dr. E. Wheeler 2129 W. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 62643

REGISTERED NO. E 62643

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2257 N. Fulton Ave (ST.) (5-A) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Carrie Hanstiehl

(a) RESIDENCE No. 2257 N. Fulton Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Hanstiehl

6 DATE OF BIRTH (month, day, and year): Feb. 18, 1850

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wilson Hanstiehl (Address) 2257 N. Fulton Ave

15 [illegible] Registrar

V 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24. 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Nov 24, 1930

that I last saw her alive on Nov 23, 1930

and that death occurred, on the date stated above, at 5.40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) E. Miles Wheeler M. D.

Nov 1930 (Address) 2129 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral

DATE OF BURIAL: 11/26 1930

20 UNDERTAKER: Williams

ADDRESS: 1217 E. Fond St

Spec—0 30—A & Co—250 Bks

Dr Sullivan 1701 W Fulton Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62644

CERTIFICATE OF DEATH

E 62644
1-PLACE OF DEATH

REGISTERED NO. 129 E 62644

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3204 Belvedere Ave ST. 27-55 (WARD)

2-FULL NAME Henry H. Tillson

(a) RESIDENCE NO. 3204 Belvedere Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Marie Moffitt Tillson

6 DATE OF BIRTH (month, day, and year): Nov 11, 1849

7 AGE: Years 81 | Months 0 | Days 12 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tailor Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Henry H Tillson

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Harriett Hull

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Marie Tillson 3204 Belvedere Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 19th, 1930, to Nov 23rd, 1930
that I last saw him alive on Nov 23rd, 1930
and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis (duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptomatology

(Signed) W. J. Sullivan M. D.
Nov. 24, 1930 (Address) 1701 W Fulton Ave

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 11/26 1930

20 UNDERTAKER: W M Cook — ADDRESS: 1212 Druid St

NOV 25 1930

Spec.—9-30—A. & Co.—250 Bks. Dr Norwood 900 W. Fayette St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62645

E 62645

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No 212 N. Schroeder St. 18-26 WARD)

2. FULL NAME Margaret A. Schomm

(a) RESIDENCE NO. 212 N. Schroeder St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ RETRACTED of (or) WIFE of William Schomm

6 DATE OF BIRTH (month, day, and year) 1/26/1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Landsman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Charles Landsman
(Address) 212 N. Schroeder St.

15 Filed ... 19... Registrar

25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 18 30, to Nov 23, 19 30

that I last saw h... alive on Nov 23, 19 30

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Norwood M. D.

Nov 24 30 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 11/26/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62646 ✓ E 62646

REGISTERED NO. 40

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. ST. 8-17 WARD)

2—FULL NAME Elizabeth Johnson

(a) RESIDENCE NO. 1744 E. Preston ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Divorced

If married, widowed, or divorced (or) WIFE of Dallie V. Johnson

DATE OF BIRTH (month, day, and year) May 21, 1898

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	6	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work factory

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco

(c) Name of employer Eclipse Mfg. Co. Balto.

BIRTHPLACE (city or town) (State or country) Selma Harnett

10 NAME OF FATHER Elias Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh N.C.

12 MAIDEN NAME OF MOTHER Amelia Harnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Raleigh N.C

Informant Hospital records

(Address)

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-22, 1930, to 11-24, 1930, that I last saw her alive on 11-24, 1930, and that death occurred, on the date stated above, at 2:50 A m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

due to adhesion from pelvic inflammatory disease.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Paralytic Ileus (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 11-22-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Robert V. Chenault M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 11/26/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—9-30—A. & Co.—250 Bks.

E 62647 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62647

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No 1102 Forrest ST. 10-15 WARD)

2. FULL NAME Ann. Conroy

(a) RESIDENCE NO. 1102 Forrest St ST. ..... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 0 mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James H. Conroy

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Martin Gaietty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann. Dillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary Brennan
(Address) 1102 Forrest St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24, 1930

17
I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930, to Nov 24, 1930
that I last saw her alive on Nov 23, 1930
and that death occurred, on the date stated above, at 2.07 a m.

The CAUSE OF DEATH was as follows:
Lobar Pneumonia
(right base)
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Chr Myocarditis & Asteno Hypertension (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) Wm. R. Geraghty M. D.
11/26/30 (Address) 2215 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 11/28/1930

20 UNDERTAKER Lowe Cook — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 62648

HEALTH DEPARTMENT—CITY OF BALTIMORE

118602

E 62648

CERTIFICATE OF DEATH

REGISTERED NO. 27-54

1—PLACE OF DEATH Maryland Gen. Hospital

CITY OF BALTIMORE: (No. Baltimore ST., Md. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hall Bost

(a) RESIDENCE NO. 1714 Sulgrave Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Grace Bost

DATE OF BIRTH (month, day, and year) June 7-1881

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	5	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Concord North Carolina

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant J. C. H. Bost

(Address) Mount Washington

Filed ..... 19..... C. HARRISON JONES, M. D.

Registrar

25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 22-30

17 I HEREBY CERTIFY, That I attended deceased from November 22, 19 30 to November 22, 19 30

that I last saw him alive on November 22, 19 30

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

Paralysis of Intestine

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 hour ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov 22-30

Was there an autopsy? No

What test confirmed diagnosis? Appendectomy

(Signed) Robert V. Chenowith, M. D.

19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Ramsel Cemetery

DATE OF BURIAL Nov 25 19 30

20 UNDERTAKER E. S. Marshall

ADDRESS 353 Lake Rd

Spec.—1-30—M. & T.—250 Bks

E 62649 HEALTH DEPARTMENT—CITY OF BALTIMORE 131 E 62649

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospitals St., [illegible] WARD)

2-FULL NAME Washington Reid

(a) RESIDENCE NO. 707 Dolphin St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) July 12, 1895

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	4	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Charlotte N. C

10 NAME OF FATHER Julius Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Mary Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

Informant Effie Reed

(Address) 707 Dolphin St

Filed NOV 25 1930 19 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23-30

17 I HEREBY CERTIFY, That I attended deceased from 9-18, 1930, to 11-23, 1930,

that I last saw him alive on 11-23, 1930

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis Left.

(duration) yrs. 4 mos ? ds.

CONTRIBUTORY (Secondary). Myocardial Insufficiency

Surgical (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical X Ray

(Signed) Luther E. Linthicum, M. D.

, 19 (Address) Balto City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-25-30

20 UNDERTAKER M. Dent Eurd

ADDRESS [illegible]

1-30—M. & T.—100 B—50L

E 62650

Dr Linthicum

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

E 62650

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 17-24 (WARD)

2-FULL NAME Cordelia Bell

(a) RESIDENCE NO. 910 N Bonaparte St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bell

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md.

PARENTS

10 NAME OF FATHER John Cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Georgianna Budd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Bell

(Address) 910 N Bonaparte

15 Filed NOV 25 1930 192 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, autopsy or inquiry) autopsy thereon and from the evidence obtained by said (inquest, autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

Asthenia (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Leslie Hall, M. D. Coroner

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

20 UNDERTAKER Dennis Eaton

DATE OF BURIAL 11-25 1930

ADDRESS 916 Pine

Spec.—1-30—M. & T.—250 Bks

E 62651 E 62651F

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/v

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 2-2-30

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Maker

(a) RESIDENCE NO. 639 W. Lee st. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Elnora Maker

DATE OF BIRTH (month, day, and year) 1905

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Thomas Maker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Rose

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

Informant .....
(Address) Hospital Records

FILED NOV 25 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1930, to Nov. 23, 1930, that I last saw h im alive on Nov. 23, 1930 and that death occurred, on the date stated above, at 10.50 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) Unknown yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Tenner, M. D.

11-24 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-25 1930

20 UNDERTAKER Samuel Taylor

ADDRESS 916 Gay ave

pec.—1-30—M. & T.—250 Bks.

E 62652 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62652

94 62652

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 5-8 (WARD)

2-FULL NAME Anabell McCants

(a) RESIDENCE NO. 1317 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) June 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Jacob McCants

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Nora Guffon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

Informant JOHNS HOPKINS HOSPITAL

(Address)

Filed Nov 25 1930, 19 C. HUDSON JONES, M.D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 23/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to November 23, 1930, that I last saw h Ca alive on November 23, 1930, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. one mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Findings

(Signed) C. C. Godwin M. D.

Dec. 1, 1930 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet cemetery

DATE OF BURIAL Nov 26 1930

ADDRESS 1691 Orleans st

20 UNDERTAKER Edward Bryan

Spec.—9-30—A. & Co.—250 Bks

E 62653

E 62653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Waldo ST. 7-9 WARD)

2 FULL NAME Mary Elizabeth Warren

(a) RESIDENCE NO. 1608 Waldo ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced (or) WIFE of George Warren

6 DATE OF BIRTH (month, day, and year) UNKNOWN

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER UNKNOWN

11 BIRTHPLACE OF FATHER (city or town) (State or country) UNKNOWN

12 MAIDEN NAME OF MOTHER UNKNOWN

13 BIRTHPLACE OF MOTHER (city or town) (State or country) UNKNOWN

14 Informant (Address) George Warren 1608 Waldo St

Filed NOV 26 1930 C. HAMPSON JONES, M. D. Registrar

51930 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1930, to Nov 24, 1930

that I last saw her alive on Nov 24, 1930

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

If sided hemiplegia (duration) yrs. 6 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bld. pressure Urinanalysis

(Signed) Rayner Browne M. D.

19 (Address) 1500 E. Madison St

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: Nov 26 1930

20 UNDERTAKER: Edward Kenyon — ADDRESS: 1631 Orleans St

Spec.—2-29-28—L. F. S.—500 Blks.

E 62654

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62654

CERTIFICATE OF DEATH

REGISTERED NO. 494

1—PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. Eden & Madison ST. 1125 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William McKew

(a) RESIDENCE NO. 517 N. Eutaw ST., WARD

(Usual place of abode) (If non-resident give city nr town and State)

Length of residence in city nr town where death occurred yrs. mns. ds. How lnng in U. S., if fnreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widnwed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

1859

DATE OF BIRTH (month, day, and year) 1859

AGE Years	Mnnths	Days	If LESS than 1 day, hrs. or min.
71 years			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Snow Hill Md.

10 NAME OF FATHER Patrick McKew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records

(Address)

Filed C. HAMPSON JONES, M.D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 6 1930, to Nov. 24, 1930, that I last saw h[illegible] alive on November 27, 1930 and that death occurred, nn the date stated above, at 1.05 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with Metastasis to Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duratinn) yrs. mos. ds.

18 Where was disease cnntracted if not at place nf death? None

Did an operation precede death? Date of

Was there an autnpsy?

What test cnnfirmed diagnosis?

(Signed) John T. Gennett M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature nf Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Valley

DATE OF BURIAL Nov 26 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

F 1930

Spec.—1-30—M. & T.—250 Bks

E 62655

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62655

X113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard and Greene ST. 4-30 WARD)

2-FULL NAME Harry Steelman

(a) RESIDENCE NO. 56 Shipway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) April 14 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Eugene Steelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Mary E Dale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Eugene Steelman

(Address) 56 Shipway Dundalk

Filed NOV 25 1930, 19 C. HAMPSON JONES, M.D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1930, to Nov. 24, 1930, that I last saw him alive on Nov 24, 1930, and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Lynn, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Nov 26 1930

20 UNDERTAKER John Ahern

ADDRESS 2 E Eager

1-30—M. & T.—100 B—50L

62656

Fraser

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62656

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST. 1816 WARD)

2-FULL NAME Miss Catherine Fraser

(a) RESIDENCE NO. 2443 E. Hoffman ST., ... WARD Washington DC

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work N. W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Arthur Fraser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winnie McGinity

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret V. Brinn

(Address) 503 H St. Washington DC

Filed ..... 19 ..... Registrar .....

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fell down stairs at home
Fracturing [illegible] and
4 mos - Hemothorax

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [signature] Coroner, M. D.

Dec 4 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/26 1930

ADDRESS

UNDERTAKER Henry W. Myers and Son 805 W. Calvert

Cor.—10-10-29—A Co.—100 Bks.

62657

Michael P. Dunn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62657

CERTIFICATE OF DEATH

107005

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital St., 14-28 (Ward)

2-FULL NAME ~~Ed~~ M P Dunn

(a) RESIDENCE NO. 443 S Stricker St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work B & O R R
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) England
(State or country)

PARENTS

10 NAME OF FATHER Pat. Dunn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Dunn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hugh Dunn
(Address) 443 S Stricker

15 Filed NOV 25 1930 C. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
(Cause primary)
Probably by Stroke
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O'Boyle, M. D.

Nov 25 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 25 Lt. 19

20 UNDERTAKER F A Jones

ADDRESS 111 S Gilmor

Spec.—1-30—M. & T.—250 Bks.

E 62658

HEALTH DEPARTMENT—CITY OF BALTIMORE E 62658

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 W Barre. ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roze Bradunas

(a) RESIDENCE NO. 640 W Barre ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. * mos. * ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-residents give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of

DATE OF BIRTH (month, day, and year) No. 1863

AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
67				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lithvania

10 NAME OF FATHER M. Ravlinaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

Informant M. Ravlinaitis

(Address) 406 S Paca St.

Filed DEC 1930, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930, to Nov 23, 1930, that I last saw her alive on Nov 22, 1930, and that death occurred, on the date stated above, at 3 pm m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Finnegan M.D.

11/24/30 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additioonal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Nov. 26 19 30

20 UNDERTAKER John Grebliauckas

ADDRESS 423 S Paca St

Spec.—12-9-25—A Co.—200 Bks.

E 62659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 62659

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 837 Leadenhall St. 27-31 Ward)

2-FULL NAME John H. Lewis

(a) RESIDENCE NO. 837 Leadenhall St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Marrid

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lewis

7 DATE OF BIRTH (month, day, and year) Dec 25 1868

AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	10	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) _____

(State or country) Va

10 NAME OF FATHER Geo T Lewis

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Fletcher

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Va

14 Informant Mary Lewis

(Address) 837 Leadenhall St

15 Filed 1930 C. Hunson Jones, M.D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/22 1930, to 11/24, 1930, that I last saw him alive on Nov 24, 1930, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? usual signs

(Signed) D. H. Caswell, M. D.

11/24 1930 (Address) 830 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn St — Date of Burial Nov 27 1930

20 UNDERTAKER S. F. Brown Sons — ADDRESS 109 W Mt St

pec.—1-30—M. & T.—250 Bks.

E 62660 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62660

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alton Price Jr

(a) RESIDENCE NO. 608 Highland ave ST., Towson Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	—

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) July 6-1929 Sunnoon

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4 ~~5~~	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Alton Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Rowland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

Filed 12-5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-23-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov-9, 1930, to Nov 23, 1930, that I last saw him alive on Nov 23, 1930, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(duration) yrs. mos 1 8 ds.

CONTRIBUTORY (Secondary) Chronic pneumonia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 11-7-30 Mastoidectomy

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) J. C. Goldwin, M. D.

11/24 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem — DATE OF BURIAL Nov 25 1930

20 UNDERTAKER Wm J. Tickner & Sons — ADDRESS No. 1 Pa

Spec.—1-12-23—M&T—500 Blks.

E 6266I

E 6266I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3801 Fredkan (Ward) 20-21

2-FULL NAME Lucy Virginia Riggin

(a) RESIDENCE NO. 3801 Freak Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	W	widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H. Riggin

7 DATE OF BIRTH (month, day, and year) Nov. 13, 1859

8 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	0	11	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Somerset Co Md

10 NAME OF FATHER Wm S. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane A. Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Mabel V. Johnson

(Address) Clayton Del Box 57.

15 Filed C. HAMPSON JONES, M. D. Registrar

25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1930, to Nov 24, 1930, that I last saw her alive on Nov 24, 1930 and that death occurred, on the date stated above, at 2 30 P M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis indefinite

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3801 Freak Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) F. L. Kyser, M. D.

, 19 (Address) 3328 Fredkan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Salisbury Md. DATE OF BURIAL Nov 25 30

20 UNDERTAKER Wm J. Dickerson ADDRESS Norfolk Va

Spec.—1-30—M. & T.—250 Bks

E 62662 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 62662

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addison L. Dougherty

(a) RESIDENCE NO. 2115 N. Guilford ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Anna R. Dougherty

DATE OF BIRTH (month, day, and year) Mch. 3, 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	8	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping commissioner

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Wilmington

(State or country) Delaware

10 NAME OF FATHER John Dougherty

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Delaware

12 MAIDEN NAME OF MOTHER Jennie Byrd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

Informant Hospital Records

(Address)

Filed 11-24, 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1930, to Nov. 23, 1930,

that I last saw him alive on Nov. 23, 1930,

and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerotic Cardio vascular Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) David Turner, M. D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Cem. Va.

DATE OF BURIAL 11/26 1930

20 UNDERTAKER Mary A. Gawthrop

ADDRESS 2839 Raynes

pec.—1-30—M. & T.—250 Bks.

41123
E 62663

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001
E 62663

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-67 WARD)

2-FULL NAME Louise Humpheries

(a) RESIDENCE No. 3026 Mosher St ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 26 - 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md —

10 NAME OF FATHER Thomas Humphries

11 BIRTHPLACE OF FATHER (city or town) (State or country) Da —

12 MAIDEN NAME OF MOTHER Marie Buschman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

Informant JOHNS HOPKINS HOSPITAL Records

(Address)

NOV 25 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Nov. 22, 1930, that I last saw her alive on Nov. 22, 1930, and that death occurred, on the date stated above, at 11 10a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hosp.

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Findings

(Signed) A. M. C. Kittner, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 11/25 19 30

20 UNDERTAKER Harry V. Nitzel, 410

ADDRESS Edmondson Av

pec.—1-30—M. & T.—250 Bks

E 62664 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-801 74 E 62664

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., H-7 WARD)

2-FULL NAME Wm French

(a) RESIDENCE No. 160 N Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

DATE OF BIRTH (month, day, and year) ? Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work War Veteran 08

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Record

(Address)

FILED 11 25 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-30

17 I HEREBY CERTIFY, That I attended deceased from 11-20, 1930, to 11-22, 1930,

that I last saw h alive on 11-22, 1930,

and that death occurred, on the date stated above, at 5½ A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Geyho, M. D.

11/22, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem.

DATE OF BURIAL 11/25 1930

20 UNDERTAKER Harry T. Witte, 4101

ADDRESS Edmondson Ave.

Spec.—1-30—M. & T.—250 Blks.

62665

HEALTH DEPARTMENT—CITY OF BALTIMORE

62665

100-00

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., (WARD) 1069

2-FULL NAME Charles J. Callahan

(a) RESIDENCE NO. 2219 W. Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W. Cath.	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mary E. Callahan

DATE OF BIRTH (month, day, and year) July 7-1878

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	4	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Dept. Store

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER William Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Mary E. Callahan

(Address) 2219 W. Baltimore St.

Filed DEC 5 1930 C. V. HAMPSON-JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23-1930

17 I HEREBY CERTIFY, That I attended deceased from 11-22-30, 19..... to 11-23-39, 19..... ,

that I last saw him alive on 11-23-30, 19..... ,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ..... yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical.

(Signed) Lawrence Mc Serra, M.D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Nov. 27 1930

20 UNDERTAKER George L. Schwatt — ADDRESS 1101 Fiedk Ave.

Spec.—1-30—M. & T.—250 Blks

62666

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 62666

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2230 E. Chase ST. 8-12 WARD)

2-FULL NAME Wm Zeltman

(a) RESIDENCE NO. 2230 E. Chase ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Zeltman

DATE OF BIRTH (month, day, and year) Aug 21 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	3	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) self

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Frederick Zeltman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mahrenz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Rose Zeltman

(Address) 2230 E. Chase St

Filed NOV 25 1930 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 17th 1930, to Nov 24 1930.

that I last saw him alive on Nov 23 1930.

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Months Practically Always.

CONTRIBUTORY (Secondary) Myocardial Decay (duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm G Leyh M. D.

, 19 (Address) 1516 W. Fayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lowe

DATE OF BURIAL Nov 26 1930

20 UNDERTAKER Philip Stewig

ADDRESS 2016 Eutaw St

Spec.—1-30—M. & T.—250 Bks.

E 62667

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62667

CERTIFICATE OF DEATH.

REGISTERED NO. ____

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd McLane

(a) RESIDENCE NO. Elkton, Md ST., ____ WARD ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 1 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Margaret McLane

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	60?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Allen McLane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Leah Hutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant G. D. Abernethy

(Address)

Filed 25 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1930, to Nov 25, 1930, that I last saw him alive on Nov. 25, 1930, and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(duration) ____ yrs. ____ mos 7 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 17 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of ____

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton B. Kirsh, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md DATE OF BURIAL Nov. 28 1930

20 UNDERTAKER G. D. Abernethy ADDRESS Elkton Md.

Spec.—1-30—M. & T.—250 Bks.

E 62668

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62668

CERTIFICATE OF DEATH.

REGISTERED NO. 100-081

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Lyndenham Hospital ST. 15-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Young

(a) RESIDENCE NO. 1332 No Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 29, 1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	11	2 3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Jas Butler

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel Young

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

Informant Ethel Young

(Address) 1332 No Gilmor St

Filed NOV 25 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1930, to Nov 23, 1930, that I last saw her alive on Nov. 23, 1930, and that death occurred, on the date stated above, at 7 40 p.m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Meningitis

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? 1332 No Gilmor St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) I. Peter Mercantin, M. D.

, 19 (Address) Lyndenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL NOV 26 1930

20 UNDERTAKER Thomas E. Nelson

ADDRESS 1303 Pennsylvania Ave

Spec.—1-30—M. & T.—250 Bks

E 62669

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62669

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3303 (St.) Hamilton Ave (WARD) 86

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Silas B. Hooker

(a) RESIDENCE NO. 3303 Hamilton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Ida E. Hooker

DATE OF BIRTH (month, day, and year) Aug. 10th 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	3	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Grain Farm

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Calvert Co. Maryland

10 NAME OF FATHER William H. Hooker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Maryland

12 MAIDEN NAME OF MOTHER Mary Gildons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Maryland

Informant Gilbert C. Hooker

(Address) Ridge St. Mexico Co. Md.

Filed ..... 19 ..... Registrar

J 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 30, to 11/23 19 30, that I last saw h~~e~~ alive on 11/23 19 30 and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - Sclerosis

Chr. Interstitial Nephritis

Hypertension.

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Kyle W. Foley M. D.

19 (Address) 5702 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waters Memorial Cemetery

DATE OF BURIAL Nov 26 1930

20 UNDERTAKER Frederick Lassahn Sons

ADDRESS 7401 Belair Rd

Spec.—8-16-29—L. F. S.—100 Bks.

E 62670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62670

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 212 W. Monument St. ST., 11-25 WARD)

2—FULL NAME Robert L. Hoy

(a) RESIDENCE NO. 212 W. Monument St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alice Beverly

DATE OF BIRTH (month, day, and year) Dec. 25, 1863

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	10	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager of Dept. Store

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

BIRTHPLACE (city or town) Va.
(State or country)

10 NAME OF FATHER Thomas Hoy

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Thomas F. Hoy

(Address) 5203 Bamford Ave.

Filed DEC 2 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Nov 23, 1930, that I last saw ~~him~~ alive on Nov 22, 1930, and that death occurred, on the date stated above, at 3, a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Contributory to My Knowledge (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

to My Knowledge (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed Diagnosis? Surgical

(Signed) A. L. Rayle, M. D.

19 (Address) Wentworth Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov. 26 1930
20 UNDERTAKER	ADDRESS
Martin Daly & Sons	1827 N. North Ave.

pec.—1-30—M. & T.—250 Bks.

E 62671 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62671

CERTIFICATE OF DEATH.

REGISTERED NO. 142

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Eutaw ST. 7 WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Wortman

(a) RESIDENCE No. 2609 Gibson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Howard Wortman Jr.

DATE OF BIRTH (month, day, and year) March 23 1908

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	7	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER James Hanks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Cawley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md

Informant Mr Howard Wortman

(Address) 2609 Gibson Ave

Filed NOV 25 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-30.

17 I HEREBY CERTIFY, That I attended deceased from 11-21-30, 19 ..., to 11-22-30.

that I last saw h alive on 11-22-30, 19 ...

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rt Breast

Metastasis Osteosarcoma

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Hom

Did an operation precede death? Yes Date of 11/22/30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 26 19 30

20 UNDERTAKER Charles P Burns — ADDRESS 1501 E Fort Ave

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62672 — 101-001 — E 62672

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 23-32 ST., WARD)

2-FULL NAME George E. Bookhultz.

(a) RESIDENCE NO. 1534 Clarkson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Park Labor gen'l

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Park Board

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John F.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant (Address) Records of Balto. City Hosp.

Filed 251930 19 HAROLD C. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-30

17 I HEREBY CERTIFY, That I attended deceased from 11-17-30, 19, to 11-24-30, 19,

that I last saw h... in life on 11-24-30 19,

and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Jas. E. Arnold Jr, M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL Nov 22 19

20 UNDERTAKER A. Howard Evans

ADDRESS 2[illegible] Fulton

Spec.—9-30—A. & Co.—250 Blks

E 62673

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62673

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2607 W Fayette St. (WARD) 20-69

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Dora Clara Benner

(a) RESIDENCE NO. 2607 W. Fayette St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How Long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Henry S Benner

6 DATE OF BIRTH (month, day, and year) Aug 3 - 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Christopher Link

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick H. Benner.

(Address) 2607 W. Fayette St.

25 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23-30

17

I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1930, to Nov. 23, 1930

that I last saw h alive on Nov. 22, 1930

and that death occurred, on the date stated above, at 12 30 M.

The CAUSE OF DEATH* was as follows:

Chron. Int. Nephritis

Diabetes Mellitus

Chron. Arteriosclerosis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. S. Moore M. D.

11 25 1930 (Address) 276 Ashburton St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	11/26 1930
20 UNDERTAKER	ADDRESS
Mrs C. Miller & Son	2334 Jeffer 11

Spec.—3-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62674

CERTIFICATE OF DEATH.

91-002 E 62674

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 10-14 WARD)

2-FULL NAME Anthony Schmall

(a) RESIDENCE NO. Preston & Valley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 3rd 1858

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	3	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Hungary

10 NAME OF FATHER Michael Schmall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Kochay

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Little Sisters of the Poor
(Address) Preston & Valley

25 1930 H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 25 Nov. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930, to Nov 25, 1930, that I last saw h~ alive on Nov 24, 1930 and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Uremia (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Demarchus M. D.

11/25 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Nov. 26 1930

20 UNDERTAKER Rita Niedefeld — ADDRESS 14 Greenmount Ave

pec.—1-30—M. & T.—250 Bks.

E 62675 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62675

113

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 6-10 WARD)

2-FULL NAME Delores Kerchner

(a) RESIDENCE NO. 2123 Moyer ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1y. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

If married, widowed, or divorced (HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) July 21-1929

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katherine Wilke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant JOHNS HOPKINS HOSPITAL, Records

(Address)

Filed 5-1930 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-23-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1930, to Nov 23, 1930, that I last saw her alive on Nov 23, 1930, and that death occurred, on the date stated above, at 5 15 p m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Cardiitis

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? yes.

(Signed) J. C. Goldwin, M. D.

11/24 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 11/26 1930

20 UNDERTAKER J. J. Moan

ADDRESS 3000 E Balto

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62676 — CERTIFICATE OF DEATH — 101-001 — E 62676

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Md. Genl. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert W. Cole

(a) RESIDENCE NO. Owings Mill, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Oct. 8, 1923

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	1	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolboy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Owings Mill, Md.

10 NAME OF FATHER: Lawrence E. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ethel Merkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: Lawrence E. Cole.

(Address) Owings Mill Md.

Filed Nov 25 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1930 to Nov. 25, 1930

that I last saw him alive on Nov. 25, 1930

and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Robert W. Cornwell, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — DATE OF BURIAL: Nov 28 1930

20 UNDERTAKER: J. F. Cline & Sons — ADDRESS: Reisterstown Md.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 62677

CERTIFICATE OF DEATH

E 62677

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospital ST. 9-46 WARD)

2-FULL NAME Ramon H Whiting

(a) RESIDENCE NO 514 E 23 St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Whit	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma A. Whiting

6 DATE OF BIRTH (month, day, and year) Nov 30 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Office
(c) Name of employer Crown Cork & Seal

9 BIRTHPLACE (city or town) (State or country) Balt. Co.

PARENTS

10 NAME OF FATHER Fairfax H Whiting

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alexandria Va.

12 MAIDEN NAME OF MOTHER Caroline Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co

14 Informant Mrs Emma A Whiting
(Address) 514 E 23 St

15 Filed ..... C. HAMPSON JONES, M. D. Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigating (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigating (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D. Coroner

Nov 24 1930 (Address) 7102 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov. 26 1930

20 UNDERTAKER Mary M. Wiedefield — ADDRESS 501 E 22 St

1-30—M. & T.—100 B—50L

(Daisy Fanacita)

E 62678

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62678

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4811 Hilabird ave ST., 36-37 WARD)

2-FULL NAME Daisy Fanacita

(a) RESIDENCE No 4811 Hilabird ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
fmale	wht	marrid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Fanacita

6 DATE OF BIRTH (month, day, and year) June 11 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	5	13 14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of Industry, business, or establishment in which employed (or employer) Self 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Aron Morgret

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Jane Mary [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Lizzie D. Morgret
(Address) Ellicott City Md

15 Filed Nov 28 1930 THOMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Carcinoma Rectum

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Landon, M. D. Coroner

Nov. 28, 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fort Lawton Pa

DATE OF BURIAL Nov. 28 1930

20 UNDERTAKER H. Steig-mothom Jr.

ADDRESS Ellicott City

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62679

CERTIFICATE OF DEATH

186-001

E 62679

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found dead at

City of Baltimore: (No.) North Bt & B to O RR St., 16-38 Ward

2-FULL NAME John Brothers

(a) RESIDENCE NO. Not Known St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Not Known

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... 19.. Registrar

NOV 25 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigated (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigated (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Skull due to Steam RR Engine of B & O RR. Accident. Came to his death there (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Hanlon, M. D.

11-15 1930 (Address) 704 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
PUBLIC CEMETERY.

DATE OF BURIAL NOV 25 1930 19

20 UNDERTAKER
Commissioner Health.

ADDRESS

S. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62680 E 62680

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 26-64 WARD)

2-FULL NAME Roberta Neilson

(a) RESIDENCE NO. 5506 Stonington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of Annie Thomas Neilson

DATE OF BIRTH (month, day, and year) Feb 17, 1852

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Unknown Baltimore Md

10 NAME OF FATHER Joseph Neilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Baltimore Md

12 MAIDEN NAME OF MOTHER Julia Ann Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Baltimore Md

Informant Roberta Echenrode

(Address) 5506 Stonington Ave

C. HAMPSON JONES, M. D.

Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1930, to Nov. 24, 1930, that I last saw him alive on Nov 24, 1930, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

10 min. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Oscar E Hubbard, M. D.

, 19 (Address) 409 Cornwall St (Church Home)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Nov 26 1930

20 UNDERTAKER John O Mitchell & Sons — ADDRESS Mc Culloh Chas

Spec.—1-12-23—M&T—500 Blks.

E 62681

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62681

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1052 E Gay St ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Frederick Stanger

(a) RESIDENCE NO. 1052 E Gay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE: Elizabeth Stanger

7 DATE OF BIRTH (month, day, and year): Nov 4th 1860

8 AGE: Years 70 | Months — | Days 20 | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

10 BIRTHPLACE (city or town) (State or country): Germany

11 NAME OF FATHER: Fred'k Stanger

12 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

13 MAIDEN NAME OF MOTHER: Unknown

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

15 Informant: Henry C. Stanger

(Address) 2231 E. Baltimore St

1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-24 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-15 1930 to 11-24 1930

that I last saw h[illegible] alive on 11-23 1930

and that death occurred, on the date stated above, at 5-0 (m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Anemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

11-25, 1930 (Address) 1052 E Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney Valley Memorial Gardens | DATE OF BURIAL: Nov 26 1930

20 UNDERTAKER: F. A. Shepherd | ADDRESS: 150 N. Gilmor St

pec.—1-30—M. & T.—250 Bks.

E 62682 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 62682

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital 2435 St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felix Katawski

(a) RESIDENCE NO. 1140 Cooksey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 1882

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oil

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Andrew Kotowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Dominika Lesniewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Wladyslawa Kotowski

(Address) 1140 Cooksie St.

Filed ..... 19 ..... Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930, to Nov 23, 1930.

that I last saw h.. alive on Nov 23, 1930

and that death occurred, on the date stated above, at 6 40 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

, 19 (Address) 1st Jersey Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Nov 26 1930
20 UNDERTAKER	ADDRESS
John M Weber	1012 Chester

Spec.—9-30—A. & Co.—250 Bks.

N° Succession 2340 Eutaw Place
Jaf 2360 ✓

62683 HEALTH DEPARTMENT—CITY OF BALTIMORE 62683

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2313 Windsor Ave. WARD) 15-60

REGISTERED No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miranda C. Swift

(a) RESIDENCE No 2313 Windsor Ave ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred 40 yrs. mos ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 19th 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Philip Swift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Wm Sample
(Address) 2313 Windsor Ave

15 Nov 30 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24th 1930

17

I HEREBY CERTIFY. That I attended deceased from Aug. 15, 1929, to Nov. 24, 1930

that I last saw h.. alive on Nov. 24, 1930

and that death occurred, on the date stated above, at 10.55 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio-vascular-renal disease

several years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Oct. 24, 1930

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. A. Sussman M. D.

19 (Address) 2340 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 11/26/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

E 62684 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62684

CERTIFICATE OF DEATH. 57

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olive Hallard

(a) RESIDENCE NO. 1421 Lowman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Wh	Widow

If married, widowed, or divorced (HUSBAND of or) WIFE of George Hallard

DATE OF BIRTH (month, day, and year) 1875

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Anna Hallard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Mrs G. Hallard

(Address) 1421 Lowman St

Filed ..... 1930 C. HAMILTON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24/30

17 I HEREBY CERTIFY, That I attended deceased from 11/10, 1930 to 11/24, 1930

that I last saw her alive on 11/24, 1930

and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) multiple Staphylococcic Abscess.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory.

(Signed) Holman S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 11/29/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 N Paul St

Spec.—9-30—A. & Co.—250 Blks.

62685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 62685

REGISTERED NO. 15268

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Mrs Bertha Talbott

(a) RESIDENCE NO. 2114 Ridgehill Ave ST. WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Edward John Talbott

6 DATE OF BIRTH (month, day, and year) Nov 27th 1874

7 AGE: Years 55; Months 11; Days 28; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Frederick Ganger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marie Dolarer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Edward J. Talbott (Address) 2114 Ridge Hill

15 Filed ..., 19... C. HAMPSON JONES, JR. Registrar

51930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930, to Nov 25, 1930

that I last saw her alive on Nov 25, 1930

and that death occurred, on the date stated above, at 11.05 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov 24. 30.

Was there an autopsy? Yes (Partial)

What test confirmed diagnosis? Clinical & autopsy

(Signed) Chas L. Stengle Jr. M. D.

, 19 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetary — DATE OF BURIAL: 11/28/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE E 62686

E 62686

CERTIFICATE OF DEATH.

REGISTERED NO. 693

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2472 Shirley Ave ST. 15-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Shaffer

(a) RESIDENCE NO. 2472 Shirley ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of Anna Williams Shaffer

DATE OF BIRTH (month, day, and year) Oct 22 1873

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	1	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Automobiles

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Aurora W. Va

10 NAME OF FATHER Richard M. Shaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Sarah Ruth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

Informant (Address) Homer D. Shaffer 308 Edmondson Ave

Filed 5-1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 24 - 1930, to Nov 24 - 1930,

that I last saw him alive on Nov 24 - 1930,

and that death occurred, on the date stated above, at 8:45 - m.

The CAUSE OF DEATH* was as follows:

(Cardiac) Coronary Embolism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Phlebitis (Leg)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James D. Aldhurst, M. D.

11-25-1930 (Address) 4012 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Nov 26 1930

20 UNDERTAKER Chas. G. Black 742

ADDRESS W North Ave

Spec.—1-30—M. & T.—250 Bks

E 62687

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62687

CERTIFICATE OF DEATH.

REGISTERED NO. 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 917 Montpelier ST. (Ward) 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elara L. Owens

(a) RESIDENCE NO. 917 Montpelier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Owens

DATE OF BIRTH (month, day, and year) June 23 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	0	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER William Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Semmina Parsons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

Informant H. M. Owens

(Address) 4 Hollcrest ave

C. HAMPSON [illegible] Md

Filed 19 Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1930, to Nov. 28, 1930, that I last saw her alive on Nov. 23, 1930, and that death occurred, on the date stated above, at 2-14 Am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. G. Prentiss, M. D.

19 (Address) 634 Gorsuch ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Council Cemetery

DATE OF BURIAL Nov 26 1930

20 UNDERTAKER Chas. S. Black

ADDRESS 142 W. North ave

Spec.—1-30—M. & T.—250 Bks

E 62688

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62688

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Edgewood Sanitorium

CITY OF BALTIMORE: (No.) Bellona Ave ST. WARD 27-46

2-FULL NAME Mary Jane Hicks

(a) RESIDENCE NO. 713 Woodbourne Ave ST. Govans WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced: HUSBAND of or) WIFE of ✓

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	70			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Ireland

10 NAME OF FATHER: Robert Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Mr. Russell Hicks

(Address) 106 W. Madison St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1930, to Nov. 23, 1930, that I last saw her alive on Nov. 23, 1930, and that death occurred, on the date stated above, at 7 50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs., ... mos. 12 ds.

CONTRIBUTORY (Secondary) Primary Arteriosclerosis (duration) 10-12 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms —

(Signed) A. F. Robinson, M. D.

11/25, 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem.

DATE OF BURIAL: Nov 26 1930

20 UNDERTAKER: Wm. McKnew & Sons

ADDRESS: North Ave

Cor.—10-10-29—A Co.—100 Bks.

E 62689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

14 1001 E 62689

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Hospitals St., 3-4 Ward)

2-FULL NAME Josephine Conway

(a) RESIDENCE NO. 124 S Dallas St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Isaac Conway

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Rev. Henson
(Address) 1426 Eutaw Pl

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James McKendrew, M. D.

11-26 1930 (Address) 7002 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 11-26 1930

20 UNDERTAKER George Rathbone

ADDRESS 1765 Hanover Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

132 ✓

E 62690

CERTIFICATE OF DEATH

E 62690

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 13-59 WARD)

2—FULL NAME William L. Barber

(a) RESIDENCE NO. 613 Newington Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Husband, Ida Barber

DATE OF BIRTH (month, day, and year) Sept 27, 1866

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Maker Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

10 NAME OF FATHER William Barber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rachel Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records

(Address)

Filed NOV 26 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 30, to Nov. 25 19 30, that I last saw h alive on Nov. 25 19 30, and that death occurred, on the date stated above, at 5:55 a.m.

The CAUSE OF DEATH* was as follows:

Primary Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 11/15/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert V. Clemmitt, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL NOV 27 1930

20 UNDERTAKER Geo M Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—8-16-29—L. F. S.—100 Blks.

Guska

E 6269F HEALTH DEPARTMENT—CITY OF BALTIMORE E 6269F

90

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2128 Gamebridge ST. 1-3 WARD)

2—FULL NAME Anna Guska

(a) RESIDENCE NO. 2128 Gamebridge ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Guska

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bohemia

10 NAME OF FATHER Josef Klima

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

Informant Josefa Guska

(Address) 2128 Gamebridge

Filed 1930 HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930 to Nov 25, 1930

that I last saw her alive on Nov 23, 1930

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

1 Mitral Regurgitation

5 days

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Wm. D. M. D.

(Date) 11/26/30 (Address) 800 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov 29 1930

20 UNDERTAKER D

ADDRESS East Baltimore Nov 1930 Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62692

CERTIFICATE OF DEATH.

129 E 62692

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 609 Stirling St. 5-8 Ward)

2-FULL NAME Eva Anderson

(a) RESIDENCE NO. 609 Stirling St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Jefferson Anderson

7 DATE OF BIRTH (month, day, and year): 1883

AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

BIRTHPLACE (city or town): Va

(State or country)

10 NAME OF FATHER: Geo. Davis

11 BIRTHPLACE OF FATHER (city or town): Va.

(State or country)

12 MAIDEN NAME OF MOTHER: Anna Johnson

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Mary Morgan

(Address): 609 Stirling St.

Filed 12-9 1930

C. HAMPSON JONES, M. D. Registrar

Dat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Carter, M. D.

(Coroner)

Nov 26/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem. Date of Burial: Dec 2 1930

20 UNDERTAKER: Chas. H. Johnson ADDRESS: 416 N. Carrollton Ave.

I-30—M. & T.—100 B—50L

E 62693

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62693

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balt City Hospital ST. [illegible] WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Harris

(a) RESIDENCE NO. 920 Linn ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Harris

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Worker
(b) General nature of industry, business, or establishment in which employed (or employer): at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt City

PARENTS

10 NAME OF FATHER: Ford Ballman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mary Robinson

(Address) 410 Jerome N. J. C.

Filed Dec 1 1930 192 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus
Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James W Jenkins, M. D. Coroner

11/26, 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Nov 26, 1930

20 UNDERTAKER: Mrs Katie R Williams

ADDRESS 322 N. Schroeder St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62694

161-001

E 62694

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 624 S Wolfe street St., 2-4 Ward)

2-FULL NAME Catherine Wasielenski

(a) RESIDENCE NO. 624 S Wolfe street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 21 / 1930

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Infant.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Andrew Wasielenski

11 BIRTHPLACE OF FATHER (city or town) Balto md.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Taltys

13 BIRTHPLACE OF MOTHER (city or town) Balto, md.
(State or country)

14 Informant Catherine Taltys Mother
(Address) 624 S Wolfe street

15 [illegible] 19

Registrar

26 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Benton, M. D.

11 25 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL Nov 26th 1930

20 UNDERTAKER George A Weber

ADDRESS 705 E Lanvale st

Spec.—1-30—M. & T.—250 Bks

E 62695

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 62695

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Provident Hosp.

CITY OF BALTIMORE: (No. 1514 Division ST. 14-20 WARD)

2-FULL NAME Paul Moore

(a) RESIDENCE NO. 1606 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Union Memorial Hosp.

BIRTHPLACE (city or town) (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Records (Address) 1514 Division St.

Filed 26 1930 19

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1930, to Nov. 24, 1930, that I last saw him alive on Nov 24, 1930, and that death occurred, on the date stated above, at 9 07 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. George McDonald, M. D.

11/24, 1930 (Address) 900 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 11/26, 1930

20 UNDERTAKER Samuel Rowley

ADDRESS 1578 W Baltimore

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62696

E 62696

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH 2406 Monticello Road

CITY OF BALTIMORE: (NO. 15-65 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Catherine Buckey

(a) RESIDENCE NO. 2406 Monticello Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, (Widowed) or Divorced, (write the word)
female	white	widowed

If married, widowed, or divorced, (HUSBAND of) (or) WIFE of the late Daniel E. Buckey

DATE OF BIRTH (month, day, and year) July 31 1846

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	3	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Littlestown Pennsylvania

10 NAME OF FATHER William H. Duttera

11 BIRTHPLACE OF FATHER (city or town) Adams Co (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Louisa Kobler

13 BIRTHPLACE OF MOTHER (city or town) Adams Co (State or country) Pennsylvania

Informant Mrs. Lula K. Clemson

(Address) 2406 Monticello Rd.

Filed V 26 1930 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24-1930

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to Nov-24, 1930, that I last saw her alive on Nov-24, 1930, and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Bronchial - pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardio - Vascular - Renal (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Lula P. Clemson M. D.

(Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littlestown Pa

UNDERTAKER Geo. Weber & Son 2503 Edmondson Ave

DATE OF BURIAL 11/26/1930

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62697

CERTIFICATE OF DEATH

117 E 62697

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Christopher

(a) RESIDENCE NO. 652 Gutman ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ the late Nellie Jane Christopher

DATE OF BIRTH (month, day, and year) May 24 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	6	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 62

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md Motor Truck

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER John Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Christine Small

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

Informant Hospital records

(Address)

Filed [illegible] 19 Registrar

C. HAMPSON JONES, M. D.

261930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-1, 1930, to 11-25, 1930, that I last saw h[illegible] M alive on 11-25, 1930, and that death occurred, on the date stated above, at 7:20 A.m.

The CAUSE OF DEATH* was as follows:

acute gangrenous appendicitis

Acute peritonitis (duration) yrs. mos. 2 ds. 8

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 11/1/30 11/19/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Robert F. Clements, M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 11/28/1930

20 UNDERTAKER Em. Weber & Son ADDRESS 2503 Edmondson

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62698

CERTIFICATE OF DEATH.

90 E 62698

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Kentucky Ave. WARD) 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Frederick Woerner

(a) RESIDENCE NO. 3107 Kentucky Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Woerner

DATE OF BIRTH (month, day, and year) June 2 1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	5	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railway Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Express

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Geo. F. Woerner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant David F. Woerner

(Address) 3914 Harford Ave

(Signed) C. HARRISON JONES, M. D.

Registrar

261930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26-1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to Nov. 25, 1930,

that I last saw h[illegible] alive on Nov. 25, 1930,

and that death occurred, on the date stated above, at 2-30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 10 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arter. sclerosis Chronic

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Magruder, M. D.

11 W. Mt. Royal Ave (Address)

Nov. 29, 19 30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov. 29 1930

20 UNDERTAKER Josiah Oyler

ADDRESS 16 W. Mt. Royal Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62699 ✓ E 62699

E 62699

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Patapsco ST. 2334 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria E. Stumpf.

(a) RESIDENCE NO. 1706 Patapsco ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sebastian Stumpf.

DATE OF BIRTH (month, day, and year) July 30 1853

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	3	24	

OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER Conrad Winkle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant Sebastian Stumpf.

(Address) 1706 Patapsco St

261930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to Nov 23, 1930, that I last saw h... alive on Nov 23, 1930, and that death occurred, on the date stated above, at 358 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis ? Chr Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Dr Schwenk, M. D.

, 19 (Address) 1337 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A. Co.

DATE OF BURIAL 11-27-1930

20 UNDERTAKER E & B. Harle. 115. E. West St.

ADDRESS

Spec.—1-30—M. & T.—250 Blks

E 62700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 V E 62700

REGISTERED NO. 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Reisterstown Road & Glen ST. 27 WARD)

2-FULL NAME John B Hailes

(a) RESIDENCE No. The Plains Reisterstown Road & Glen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M Hailes

DATE OF BIRTH (month, day, and year) May 4 1861

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Calvert Co Maryland

10 NAME OF FATHER John P Hailes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Maryland

12 MAIDEN NAME OF MOTHER Mary H Beckett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Maryland

Informant Edwin Earl Hailes

(Address) 4302 Fernhill Ave

Filed 1930 19 HARRY JONES, M. D. Registrar

26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/25/30

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1925 to November 25, 1930,

that I last saw h/e alive on November 25, 1930,

and that death occurred, on the date stated above, at 10.10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory Test & Ed

(Signed) W B Hall, M. D.

19 (Address) 113 W. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Nov 27 1930

20 UNDERTAKER Harry Hilmaco & Son

ADDRESS 4204 Ridgewood Ave

0—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

62701

CERTIFICATE OF DEATH

44

E 62701

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 557 Baker ST., 14-59 WARD)

2-FULL NAME Mary Green

(a) RESIDENCE NO 557 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fml

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo Green

DATE OF BIRTH (month, day, and year): 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Own
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: Austin Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Hattie Blackfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: Gertrude Bradley

(Address): 557 Baker St

Filed 26 1930

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. E. Heuh, M. D. Coroner

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kingsdale W Va

DATE OF BURIAL: Nov 28-1930

20 UNDERTAKER: Jam. M. Chase & Son

ADDRESS: 1420 Mosher

10—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 62702

CERTIFICATE OF DEATH

62702

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) In front of 303 N. Gay St. (ST.) 8-13 (WARD)

2-FULL NAME Bryan L. Cross.

(a) RESIDENCE NO. 1111 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary E. Cross.

6 DATE OF BIRTH (month, day, and year) October 8, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brichlayer.
(b) General nature of industry, business, or establishment in which employed (or employer) Oil
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Joshua Cross.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Catherine ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

Informant Margaret Barranger. (daughter)

(Address) 1610 N. Bond St.

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas W. Reinhardt, M. D. Coroner

11/25 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Govanstown Cem't. DATE OF BURIAL Nov. 27 1930.

20 UNDERTAKER Martin Fahy & Sons ADDRESS 1827 North Ave.

C. HARRISON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62703 — REGISTERED NO. 90 ✓ E 62703

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3309 Sweetbriar ave ST., 27-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Emma N Belbin

(a) RESIDENCE NO. 6009 Reisterstown Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND (or) WIFE of Chas L. Belbin

DATE OF BIRTH (month, day, and year) May 30-

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	61	6	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady Keeper of

(b) General nature of industry, business, or establishment in which employed (or employer) Investment Company

(c) Name of employer Self.

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John E Ewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belfast, Ireland

12 MAIDEN NAME OF MOTHER Cecelia Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Mrs Emma E. Belbin

(Address) 3309 Sweetbriar ave

FILED 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1930, to Nov 23, 1930, that I last saw h.. alive on Nov 21, 1930, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) C. V. Ewart, M. D.

11-23 1930 (Address) 4136 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 26 1930
20 UNDERTAKER	ADDRESS
Robt. D. Turner	1400 W. Lombard St

0—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

62704

CERTIFICATE OF DEATH

90 E 62704

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 15-21 WARD)

2-FULL NAME Frank Wright

(a) RESIDENCE NO 1613 Presbury ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of no

DATE OF BIRTH (month, day, and year) Feb 8 1909

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	9	15	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 046
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nanta Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Viola Wright

(Address) 1613 Presbury St

Filed ..... 192 C. HAMPSON JONES, M. D.

Registrar

6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23rd 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. Seldom mos. ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) ..... Coroner, M. D.

No. 75 19 ... (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 11/26/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Lemmon

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62705 90 E 62705

CERTIFICATE OF DEATH.

E 62705

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1631 E Preston ST., 8-13 WARD)

2-FULL NAME Louise Jean Trupler

(a) RESIDENCE NO. 1631 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9/73

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	57	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer) Retail Millinery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Trupler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Sarah F. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Susan Sutter

(Address) 1631 E Preston

15 Filed Oct 26 1930, 19

C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1926, 19 , to Oct 25, 1930.

that I last saw her alive on Oct 26, 1930.

and that death occurred, on the date stated above, at 6.40 A m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

Chr. hypertrophic type

Arteriosclerosis

(duration) three years yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry B Hyde, M. D.

19 (Address) 110 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Oct 28 30

20 UNDERTAKER Stephen Jones & Son ADDRESS 4 W Madison

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62706 ✓ 129 E 62706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 10-14 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Hardy

(a) RESIDENCE NO. 806 Greenmount Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year) Oct. 7, 1863

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER William Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E. Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

PARENTS

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-30

17 I HEREBY CERTIFY, That I attended deceased from 11-21-30, 19 ..... to 11-24-30, 19 .....,

that I last saw him alive on 11-24-30, 19 .....,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease, arteriosclerotic

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Nephritis, arteriosclerotic

(duration) yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

11-25, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 11/28/1930

20 UNDERTAKER John F. Cowan & Son.

ADDRESS Gorsuch Ave

HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

242585
E 62707

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62707

113

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-11 WARD)

2-FULL NAME Doloses Crawford

(a) RESIDENCE No. 457 No. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced,~~ (write the word): Infant

6 If married, widowed, or divorced (HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 9 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hilda Sears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

261939

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1930, to Nov 26, 1930, that I last saw her alive on Nov 26, 1930, and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

diarrhea + enteritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 11/28, 1930

20 UNDERTAKER Louis Neumann

ADDRESS 325 Broadway

Spec.—1-30—M. & T.—250 Bks.

E 62708

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62708

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3918 Liberty Heights St. (W) 15-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Schmidt

(a) RESIDENCE NO. 3918 Liberty Heights ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 65 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Charles F. Schmidt

7 DATE OF BIRTH (month, day, and year): Dec-29-1845

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	10	27½	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

8 BIRTHPLACE (~~City or town~~) (State or country): Germany (Lahr-Baden)

10 NAME OF FATHER: Michael Goetz

11 BIRTHPLACE OF FATHER (City or town) Lahr Baden (State or country) Germany

12 MAIDEN NAME OF MOTHER: Salomea Lerch

13 BIRTHPLACE OF MOTHER (City or town) Lahr Baden (State or country) Germany

Informant: Mrs Chas. F. W. Schmidt (son)

(Address) 220 Springdale Ave.

Filed Dec 26 1930 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov-25-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1930, to Nov 25, 1930, that I last saw h[illegible] alive on Nov 25, 1930 and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Nov 26, 1930 (Address) 720 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Nov 28, 1930

20 UNDERTAKER: Stewart & Co. — ADDRESS: Balto Md

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62709 ✓ E 62709

CERTIFICATE OF DEATH

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 N. Patterson Park Ave. ST. 7-12 WARD)

2-FULL NAME Henry Wiefenbach

(a) RESIDENCE No 923 N. Patterson Park Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Wiefenbach

6 DATE OF BIRTH (month, day, and year) August 7, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer) 063
(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Gottlieb Wiefenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George H. Wiefenbach

(Address) 2527 E. Madison Street

Filed 12 6 1930, 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) H. K. Cattell, M. D. Coroner

Nov. 25 '30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov. 27, 1930

20 UNDERTAKER Frederick Lassahn & Sons

ADDRESS 7401 Belair R

Spec.—8-1-29—L. F. S.—100 Bks.

E 62710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 62710

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 N. Curley. ST. 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Frank Seufert.

(a) RESIDENCE NO. 810 N. Curley. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Seufert.

DATE OF BIRTH (month, day, and year) May 22-1903

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	27	6	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Transportation

(c) Name of employer Standard Shipping Co.

BIRTHPLACE (city or town) (State or country) Md Baltimore

10 NAME OF FATHER Philip P. Seufert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Barbara Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Barbara H. Seufert.

(Address) 1817 N. Regester St.

26 1930 C. PLAYSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26-1930

17 I HEREBY CERTIFY, That I attended deceased from October 16-, 1930, to November 26, 1930, that I last saw him alive on November 26-, 1930 and that death occurred, on the date stated above, at 12:50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum test.

(Signed) Chester Riland, M. D.

11-26, 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Nov 29 1930

20 UNDERTAKER John C. Muller

ADDRESS 5 E 21st.

Spec.—2-29-28—L. F. S.—500 Bks.

Time of funeral extended to 11-29-30.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. Frederick Stumpf, Undertaker 10627 A1

E 62711

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) Md. Gen. Hosp. St. 12-19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilhelm Augustine

(a) RESIDENCE NO. 115 E. Lafayette Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct. 10, 1897

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	1	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mech. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Eadmann Augustine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Wannecke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant W. Augustine

(Address) 115 E. Lafayette Ave.

Filed ..... 19 ..... Registrar

C. HARPSON OCHS, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16 . 1930 to Nov. 23 . 1930 that I last saw him alive on Nov. 23, . 1930 and that death occurred, on the date stated above, at 2:50 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 115 E. Lafayette Ave

Did an operation precede death? Yes Date of 11-16-30

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings.

(Signed) [illegible], M. D.

. 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park (Cremation)

20 UNDERTAKER Gilhom

DATE OF BURIAL 11/28 1930

ADDRESS 1214 St. Paul St

261939

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62712 — REGISTERED NO. — 100-001 — E 62712

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4018 N. Rogers Ave. ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.) — WARD

2—FULL NAME Alvin C. Eyler

(a) RESIDENCE NO. 4018 N. Rogers ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Anna F. Eyler

DATE OF BIRTH (month, day, and year): Aug 24 1876

AGE: Years 54 | Months 3 | Days 5 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Diner 684
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Frederick Co Md

10 NAME OF FATHER: Jacob M Eyler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co Md

12 MAIDEN NAME OF MOTHER: Mary E Stauk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

Informant: Anna F. Eyler
(Address) 4018 N. Rogers Ave

Filed ..., 19 ... Registrar

C. HARPER JONES, M. D.

26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Novem. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Novem. 2, 1930, to Novem. 24, 1930, that I last saw him alive on Novem. 24, 1930, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Paralysis Agitans (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical & Laboratory

(Signed) H. Delpeut, M. D.

, 19 (Address) 2430 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Nov 27 1930

20 UNDERTAKER: D. S. Marshall — ADDRESS: 3439 Gall Rd

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 ✓ E 62713

E 62713

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No.) Linden Road ST., (WARD) 15-18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harvey A. Beadles

(a) RESIDENCE NO. 1816 Dukeland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Hilda G. Beadles

DATE OF BIRTH (month, day, and year) Oct. 1, 1897

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	1	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Welder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) North Adams

(State or country) Mass.

10 NAME OF FATHER Evan Beadles

11 BIRTHPLACE OF FATHER (city or town) Wales

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hanley

13 BIRTHPLACE OF MOTHER (city or town) Salem

(State or country) N. Y.

Informant Hospital Records

(Address)

Filed Nov. 30, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1930, to Nov 26, 1930, that I last saw him alive on Nov 26, 1930, and that death occurred, on the date stated above, at 12 50 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Robert V. Chamberlain, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL North Adams Mass

DATE OF BURIAL Nov. 26 1930

20 UNDERTAKER Wm. Hickner & Sons

ADDRESS North Adams

Spec.—1-30—M. & T.—250 Bks.

2427 67 E 62714 — + 132 — E 62714

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME James CARROLL

(a) RESIDENCE NO. 7 & Bead Case ST., ... WARD Buffalo - N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 17-1866

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	9	9	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Securities & Bonds

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Ill.

10 NAME OF FATHER James Carroll

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Margaret Devine

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address)

Filed NOV 27 1930 C. HAMPTON JONES, M. D. Registrar

Pre ..... Reg. ..... Cor. .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1930, to Nov. 26, 1930, that I last saw him alive on Nov. 26, 1930, and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Post-operative shock.
Coronary Thrombosis?

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes, Date of Nov. 26, 1930.

Was there an autopsy? Yes. (Removal of Stone)

What test confirmed diagnosis? .....

(Signed) H. L. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Buffalo, N.Y.

DATE OF BURIAL Nov. 27 1930

20 UNDERTAKER Brayhead Bros due.

ADDRESS 424 N. Brdwy.

Spec. 8-16-29—L. F. S.—100 Blks.

E 62715

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62715

CERTIFICATE OF DEATH

90

REGISTERED NO. 236

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 E. York St ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marion Bianca

(a) RESIDENCE NO. 15 E. York St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	1 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatore Bianca

DATE OF BIRTH (month, day, and year) 1870

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Venezo Porozza

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Mr. Bianca

(Address) 15 E. York St

Filed 27 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-1930

17 I HEREBY CERTIFY, That I attended deceased from 11-19, 1930, to 11-25, 1930

that I last saw h[illegible] alive on 11-25, 1930

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Rheumatic & Chronic valvular disease of heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. D'Amare M. D.

11-26 1930 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 11/28 1930

20 UNDERTAKER J. Few McCully

ADDRESS 1306 E. Fort

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62716

CERTIFICATE OF DEATH

REGISTERED NO. 199 E 62716

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 62716

1-PLACE OF DEATH South Balto Gen Hosp (Ward) 33

City of Baltimore: (No. St.,

2-FULL NAME Elizabeth Tarbutton

(a) RESIDENCE NO. 1267 Riverside St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Tarbutton

6 DATE OF BIRTH (month, day, and year) Nov 17 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68	—	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Micheal's Md.

PARENTS

10 NAME OF FATHER Edw Eaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Micheals

12 MAIDEN NAME OF MOTHER Nora Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Micheals

14 Informant Mrs Nora Hubbard (Address) 1267 Riverside Ave

15 Filed [illegible] 19 [illegible] Registrar

27 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Struck & knocked down by moving auto (hit & run) (H)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

Crushed Chest (L) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hanover & Clement

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Frame, M. D.

(11-27 1930 (Address) 2139 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Michael's Talbot Co Md

DATE OF BURIAL 29 Nov 1930

20 UNDERTAKER Sherlock D Evans

ADDRESS 1301 E Fort Ave

1-30—M. & T.—100 B—50L

E 62717

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62717

CERTIFICATE OF DEATH

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2139 E. Chase St ST. 8-12 WARD)

2-FULL NAME John Charles Vakautis, Jr.

(a) RESIDENCE NO 2139 E. Chase St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto/Md.

PARENTS

10 NAME OF FATHER John Charles Vakautis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sparta, Greece

12 MAIDEN NAME OF MOTHER Marion Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant John Charles Vakautis, 2139 E. Chase St
(Address)

15 Filed 27 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Prematurity (7 mons gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.

Nov 27 1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Nov 27 1930

20 UNDERTAKER John M Weber

ADDRESS 401 E Chester St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62718 E 62718

CERTIFICATE OF DEATH.

101-60

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital St. 13-59 (WARD)

2-FULL NAME Frederick Mills

(a) RESIDENCE NO. 2453 Mc Culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	colored	single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) ? 1906

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Isaiah Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Olivia Cunell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant (Address) Benj. Mills Pokomoke City, Md

Filed 2 8 1930 19 R.E.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1930, to Nov 26, 1930, that I last saw h~~im~~ alive on Nov 26, 1930, and that death occurred, on the date stated above, at 11.25 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy.

(Signed) B. Harris M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pokomoke City Md.

DATE OF BURIAL 11/28/1930

20 UNDERTAKER Wm. Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65-101 E 62719

E 62719

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST. 18-29 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carrie Shorb

(a) RESIDENCE NO. 1224 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 24 1872

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58	58	—	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Louis Conkerly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna L. Riddleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hosp. Records

(Address)

Filed 25 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25-1930

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to Nov 25, 1930,

that I last saw h[illegible] alive on Nov. 25, 1930,

and that death occurred, on the date stated above, at 10 0 m.

The CAUSE OF DEATH* was as follows:

Myeloid Leukemia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings & Blood picture

(Signed) G. Burns Hamilton, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov-28 19 30

20 UNDERTAKER George A. Farley

ADDRESS 1800 W Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62720

CERTIFICATE OF DEATH

74-001 E 62720

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. General Hospital ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Timbs

(a) RESIDENCE NO. 3509 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E

DATE OF BIRTH (month, day, and year) June 15 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto, Md.

10 NAME OF FATHER John Timbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Caroline Meads

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

Informant Hospital records

(Address)

Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 30

17 I HEREBY CERTIFY, That I attended deceased from August 23, 1930, to Nov 25, 1930, that I last saw h/ alive on Nov 25, 1930 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (Ex)

(duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert V. Clements, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov 29 1930
20 UNDERTAKER	ADDRESS
Franklin W. Seitz	709 W 33 St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62721

CERTIFICATE OF DEATH

74-001

E 62721

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Rossiter Avenue ST. 27-45 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. J. Aull

(a) RESIDENCE NO. 510 Rossiter Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob H. Aull

DATE OF BIRTH (month, day, and year) -------

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	--	--	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Augustus D. Clemens

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not obtainable

12 MAIDEN NAME OF MOTHER Henrietta Bryden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not obtainable

Informant Herbert W. Aull

(Address) 3804 Pinewood Avenue

Filed 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27/30

17 I HEREBY CERTIFY, That I attended deceased from 11/18/30, 19..., to 11/27/30, 19..., that I last saw h[illegible] alive on 11/26/30, 19..., and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Sanders, M. D.

11/28/30, 19 (Address) 321 - E - 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 11/29 19

20 UNDERTAKER Henry U. Sears and Son

ADDRESS 805 N. Calvert

pec.—1-30—M. & T.—250 Bks

E 62722

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62722

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Blenner

(a) RESIDENCE NO. 2838 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND) of or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 17 1874

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	1	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Richmond Va.

10 NAME OF FATHER August Blenner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Hospital Record

(Address)

Dec 23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-30

17 I HEREBY CERTIFY, That I attended deceased from 11-8, 1930, to 11-25, 1930,

that I last saw h in alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2/ ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

11/25, 1930 (Address) 6 Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov 28 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto

Spec.—1-30—M. & T.—250 Bks.

62723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 62723

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U.S. Marine Hospital Baltimore, Md. ST. 11-15 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Carl J. Wagner

(a) RESIDENCE NO. 917 North Calvert St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Catherine Wagner

DATE OF BIRTH (month, day, and year) December 5, 1888

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	11	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supercargo

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. "Oritani"

086

BIRTHPLACE (city or town) (State or country) Charleston S.C.

10 NAME OF FATHER Carl B. Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Tecklenburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston S.C.

Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

Filed 23 1930, HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 22, 1930, to November 24, 1930,

that I last saw him alive on November 24, 1930,

and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis, chronic

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia, lobar Probably

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-24-30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Gordon A. Abbott, M. D.

11/25, 1930 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden — DATE OF BURIAL Nov. 28, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc. — ADDRESS 1256 North Ave.

Spec.—1-10-21—M&T—1500 Bks.

E 62724 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 129 E 62724

REGISTERED NO. E 62724

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 631 S Dolphin St. (WARD) 17-24

2-FULL NAME John H. Burke

(a) RESIDENCE NO. 631 S Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leah

6 DATE OF BIRTH (month, day, and year): 1848?

7 AGE: Years 82 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Harriett Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Leah C. Burke (Address) 631 Dolphin St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov-24 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-7- 1930 to Nov-24- 1930 that I last saw h[illegible] alive on Nov-24- 1930 10 P m. and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M.D.

Nov 27 1930 (Address) 1443 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery DATE OF BURIAL 12/1/1930

20 UNDERTAKER: Mrs. Geo. C. Holland ADDRESS 631 Druid Hill

[illegible] JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

242526

E 62725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ E 62725

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Winston

(a) RESIDENCE NO. 821 Druid Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	unknown

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) ? 1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Alfred Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant JOHNS HOPKINS HOSPITAL

(Address) Records

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26-1930

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Nov 26, 1930,

that I last saw her alive on Nov 26, 1930,

and that death occurred, on the date stated above, at 6 07 a m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Hypertension

Arteriosclerosis

(duration) 1 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical Examination

(Signed) Benjamin Baker, Jr., M. D.

Nov 26, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 11/29/1930

UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1603 Druid Hill

32 AON THOMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks

E 62726 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 62726

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3235 Brlair Road ST. 8-40 WARD)

2-FULL NAME Jacob Katz

(a) RESIDENCE NO. 3235 Brlair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

a If married, widowed, or divorced (or) WIFE of HUSBAND) of Sidonia Katz

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Grocer)

(b) General nature of industry, business, or establishment in which employed (or employer) 0&6

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Hungary

10 NAME OF FATHER Samuel Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Reza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Sidonia Katz (Wife)

(Address) 3235 Brlair Road

15 FILED NOV 29 1930 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26-30

17 I HEREBY CERTIFY, That I attended deceased from Sept-15-, 1930, to Nov-26-, 1930,

that I last saw h~~im~~ alive on Nov-26-, 1930,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

about 18 months

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

Nov 26 1930 (Address) Herman Seidel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Working Mens Circle Cem	Nov 28 1930
20 UNDERTAKER	ADDRESS
Jack Lewis	1434 E. Baltimore

pec.—1-30—M. & T.—250 Bks

E 62727

E 62727 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. 15-68

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Robinson "A" twin

(a) RESIDENCE NO. 1714 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of

DATE OF BIRTH (month, day, and year) 11/25/30

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Mercy Hospital - Balto Md

10 NAME OF FATHER Bernard Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Charlotte Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital records

(Address)

Filed 12-8-1930, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27/30

17 I HEREBY CERTIFY, That I attended deceased from 11/25, 1930, to 11/27, 1930,

that I last saw him alive on 11/27, 1930,

and that death occurred, on the date stated above, at 1 10 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) J H Gordon, M. D.

11/28, 1930 (Address) Mercy Hospital - Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Nov 29 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1498 E Baltimore St

Spec.—1-30—M. & T.—250 Bks

E 62728 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62728

161-001

CERTIFICATE OF DEATH.

REGISTERED NO. 45-60

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (WARD) "B"

2-FULL NAME Baby Boy Robinson

(a) RESIDENCE NO. 1714 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White.	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) 11/24/30

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
			2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Bernard Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Charlotte Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bernard Robinson

(Address) 1714 N. Bentalou

15 FILED NOV 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1930, to Nov 26, 1930, that I last saw him alive on Nov 26, 1930, and that death occurred, on the date stated above, at 3:10 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Premature Delivery)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests.

(Signed) G. Burns Maunder Jr. M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herring Run Cem

DATE OF BURIAL Nov 28 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1338 E Baltimore St

Spec.—8-16-29—L. F. S.—100 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62729 E 62729

CERTIFICATE OF DEATH

129 ✓

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 W Carrollton Ave ST., (WARD) 19th

2—FULL NAME Francis J Short

(a) RESIDENCE NO. 529 W Carrollton ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Peter C Short

DATE OF BIRTH (month, day, and year) May 5th 1866

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	6	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Glos Co Md

10 NAME OF FATHER Lemuel Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Swan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Peter C Short

(Address) 529 W Carrollton ave

Filed NOV 28 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 27th 30

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to Nov 29, 1930

that I last saw h.. alive on November 26 1930

and that death occurred, on the date stated above, at 10.20 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Inter Stitial Nephritis

(duration) yrs. 6+ mos. ds.

18 Where was disease contracted if not at place of death? 529 Carrollton ave

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wagner, M. D.

11/27 1930 (Address) 1209 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Nov 30 1930

20 UNDERTAKER Frank E Wright

ADDRESS 1005 Lanvale ave

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62730

CERTIFICATE OF DEATH

90 E 62730

1—PLACE OF DEATH

REGISTERED NO. 18-26

CITY OF BALTIMORE: (No.) 1110 Sarah (Street) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Co. Coleman

(a) RESIDENCE NO. 1110 Sarah Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced: HUSBAND of (~~WIFE of~~) Rosa Coleman

DATE OF BIRTH (month, day, and year): Mar 24 1889

AGE: Years 41 | Months — 8 | Days — | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: Wm. Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Emma Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

Informant: Sarah E. Fryer

(Address) 1110 Sarah St.

Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

Dec 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1930, to Nov. 24, 1930

that I last saw him alive on Nov. 24, 1930

and that death occurred, on the date stated above, at 9. P. m.

The CAUSE OF DEATH* was as follows:

Edema Interstitial Dis. Heart

Cystic Pneumonia

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David E. Wagner M. D.

11/29, 1930 (Address) 675 Schroeder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Nov. 29, 1930
20 UNDERTAKER: Mrs. Katie R. Williams	ADDRESS 322 N. Schroeder St.

0—M. & T.—100 B—50L

E 62731

E 62731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. ST., 19-27 WARD)

2-FULL NAME Raymond Bernard Mason

(a) RESIDENCE NO 1710 Carro ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Blanche Mason

DATE OF BIRTH (month, day, and year) Nov 15 1886

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44		9	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Helper in Garage
(b) General nature of industry, business, or establishment in which employed (or employer) 640
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Raymond Mason

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Fletcher

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

Informant Blanche Mason

(Address) 1710 Carro

Filed ..... 192 ..... HARRY S. JONES, M. D. Registrar

V 28 1936

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lung

(duration) ..... yrs. ..... mos. Sudden ds.

CONTRIBUTORY (Secondary) Pulmonary Phthisis

(duration) ..... yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. E. Buck, M. D. Coroner

Nov 24 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson's Cemetery

DATE OF BURIAL Nov 28, 1930

UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

Spec.—1-30—M. & T.—250 Bks.

62732

E 62732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 225 N Schroeder St. 18-26 (WARD)

2-FULL NAME Estella Parham

(a) RESIDENCE NO. 225 Schroeder St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

If married, widowed, or divorced (or) WIFE of George Parham

DATE OF BIRTH (month, day, and year) Nov 22 1906

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
24	0	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Balto. Md
(State or country)

10 NAME OF FATHER James Williams

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Mary Woods

13 BIRTHPLACE OF MOTHER Ellicott City Md
(State or country)

Informant George Parham
(Address) 225 N. Schroeder St

Filed 28 1930 19 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 24, 1930, that I last saw her alive on Nov 22, 1930, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

6 (duration) ..... yrs. mos. ds. (History)

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Dr regular

(Signed) W. S. Rawls, M. D.

11/25/1930 (Address) 201 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Nov 28, 1930

19 UNDERTAKER Mrs Katie R. Williams — ADDRESS 322 N. Schroeder St

Spec.—1-30—M. & T.—250 Bks.

E 62733

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62733

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 S. Carey ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Bakutis

(a) RESIDENCE NO. 1107 S. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Elizabeth Kudukey

DATE OF BIRTH (month, day, and year): Feb. 5-1885

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
45	-	9	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 050

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Lithuanian

10 NAME OF FATHER: John Bakutis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Agnes Dukis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

Informant: Elizabeth Bakutis

(Address): 1107 S. Carey St

Filed 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 25. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1930, to Nov. 25. 1930,

that I last saw him alive on Nov. 25. 1930,

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Urine Analysis &c

(Signed) J. Thurston, M. D.

11-27. 1930 (Address) 888 N. Lansdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: Nov. 29. 1930

20 UNDERTAKER: John. Grebhanchese

ADDRESS: 423. S. Paca St

1-30—M. & T.—100 B—50L

E 62734

E 62734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

21-29 169

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Pier No.2 Pratt St. ST. ..... WARD .....

2-FULL NAME Frederick W.Crauf.

(a) RESIDENCE NO 1003 S.Paca St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE of~~ Emma Crauf.

6 DATE OF BIRTH (month, day, and year) September 3, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	2	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing cutter.
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Nome of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Crauf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Margaret ---------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Emma Crauf.(wife)

(Address) 1003 S.Paca St.

15 Filed 2 1930, 192 C. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 25, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by drowning.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) O. H. Reinhardt, M. D. Coroner

11/28 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Co

DATE OF BURIAL 11-28-N 1930

UNDERTAKER Bernard C Harbin

ADDRESS 1044 S Paca St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62735 E 62735

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 W. Hoffman St.; 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Griffin Pitts

(Residence in Baltimore: No. 314 W. Hoffman St.; 12 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, (Month) (Day), 1865 (Year)

7-AGE, 65 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country), Boston Mass.

PARENTS.

10-NAME OF FATHER, Chas E. Pitts

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Pitts

(Address) 314 W. Hoffman St.

15- Filed 12 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1930 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1930, to Nov 24 1930, that I saw him alive on Nov 24 1930 and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary) Cardiac Thrombosis

(Duration) yrs. mos. 5 da.

(Signed) Charles H. Fowler M. D.

Nov 26, 1930 (Address) 712 S. Wash Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 28, 1930

20-UNDERTAKER Frank H. Kidder

ADDRESS 436 N. Eutaw St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62736

CERTIFICATE OF DEATH

129 E 62736

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 Bravard ST. 11-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Swift

(a) RESIDENCE NO. 928 Bravard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

a If married, widowed, or divorced WIFE of (or) HUSBAND of Jno. Swift

DATE OF BIRTH (month, day, and year) June 7 1861

AGE 60 Years 4 Months 24 Days If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (City or town) (State or country) Va.

10 NAME OF FATHER Jno. Only

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Scato

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Josie Dorsey

(Address) 928 Bravard St.

FILED 1:35 P.M. JAMESON JONES, M. D.

231930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1930, to Nov. 24, 1930

that I last saw h alive on Nov. 24, 1930

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Uremia (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis (duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno H. Tompkins, M. D.

11/26 1930 (Address) 1012 N. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Nov. 28, 1930

20 UNDERTAKER Wm. R. G. Elliott — ADDRESS 711 E. Baltimore

r.—10-10-29—A Co.—100 Bks.

E 62737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 62737

REGISTERED NO.

1-PLACE OF DEATH
ty of Baltimore: (No.) Mercy Hosp St. 18-76 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J Gettings

(a) RESIDENCE NO. 812 Mulberry St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	Col	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) 1908

AGE	Years	Months	Days	IF LESS than 1 day... hrs. or ... min.
	22		8	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer Balto City

BIRTHPLACE (city or town) Balto
(State or country)

10 NAME OF FATHER John Gettings

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Emma Pack

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant Emma Gettings
(Address) 812 Mulberry St

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:
Auto in which he was riding collided with another motor at intersection of (A)
(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Fx. B. Infect. of
Wounds — caused by accident
(Duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Schroder & Saratoga

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Frame, M. D.

11/24 1930 (Address) 2321 N. Eldeny

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-28 1930

20 UNDERTAKER D. Sam Easton

ADDRESS 916 Dolphin

28 1930

Spec.—1-30—M. & T.—250 Bks

E 62738

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62738

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division ST., 18-29 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Simmons

(a) RESIDENCE NO. 820 Pratt ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 24-1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Wm Simmons

(Address) 820 East St

Filed 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1930, to Nov. 25, 1930, that I last saw him alive on Nov. 25, 1930, and that death occurred, on the date stated above, at 7 20 p m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. George McDonald, M. D.

11/25 1930 (Address) 906 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11-28 1930

20 UNDERTAKER Daniel Fenton

ADDRESS 916 Pa ave

Spen.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62739

CERTIFICATE OF DEATH.

7H-001 E 62739

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2517 (St.) W North Ave (Ward) 5-6

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma F. Restag

(a) RESIDENCE. No. 2517 W North St. Ave Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Reston

6 DATE OF BIRTH (month, day, and year): Oct 15, 1863

7 AGE: Years 64 Months 1 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): U. S.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Dora Crandell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. S.

14 Informant (Address): Mrs Ella Godwin E. 2517 W North Ave

15 Filed: JAN 28 1930 C. HANSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930, to Nov 27, 1930, that I last saw her alive on Nov 27, 1930, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis, cerebral and general with cerebral hemorrhage with R side focal paralysis (duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Paralysis and gastritis (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs

(Signed) Hasley Call, M. D.

1/28 1930 (Address) 2207 Harrison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union

DATE OF BURIAL: 11/28 1930

20 UNDERTAKER: H. Cook

ADDRESS: 1270 Pratt St

Spec.—1-30—M. & T.—250 Bks.

E 62740 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 62740

CERTIFICATE OF DEATH. 102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (ST.) 5-63 (WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Morton Benesch

(a) RESIDENCE NO. 3925 Bellona Ave Balto Md. ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	

6 If married, widowed, or divorced HUSBAND of or) WIFE of None

DATE OF BIRTH (month, day, and year) July 1 1929

AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	1	4	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Samuel Benesch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rosa Greenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Samuel Benesch

(Address) 3926 Bellona ave

Filed 26 1930 19 per _____ C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 19 30, to Nov 27, 19 30,

that I last saw him alive on Nov 27, 19 30

and that death occurred, on the date stated above, at 11:10 P m.

The CAUSE OF DEATH* was as follows:

Multiple pulmonary abscesses
Fibropurulent pleurisy
Pyemia

(duration) _____ yrs. 3-4 mos. _____ ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) _____ yrs. _____ mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Nov 26th '30

Was there an autopsy? yes Necropsy of Abscess

What test confirmed diagnosis? Autopsy

(Signed) Charles Robert Cohen M. D.

11/28, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Rozedale

DATE OF BURIAL Nov 28 1930

20 UNDERTAKER S Fenwick Bu

ADDRESS 1127 E Balto St

Spec.—1-30—M. & T.—250 Bks.

242835

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62741

CERTIFICATE OF DEATH.

X 49 E 62741

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME Arthur Murray

(a) RESIDENCE NO. 737 Graydon Park ST., WARD Norfolk Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 8 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Regina

DATE OF BIRTH (month, day, and year) June 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	5		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER William D.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Old

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 12-3 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-28-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930, to Nov 28, 1930, that I last saw h[illegible] alive on Nov 28, 1930, and that death occurred, on the date stated above, at 330 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder-recurrent

secondary Anemia

mitral insufficiency

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Edema of lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Norfolk Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic examination

(Signed) Conrad Acton, M. D.

, 19 (Address) Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL 11/29/30

20 UNDERTAKER J. J. Thurston — ADDRESS 156 Fayette

1-30—M. & T.—100 B—50L

E 62742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62742

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 8-16 WARD)

2-FULL NAME Charles Henry Hofferbert

(a) RESIDENCE NO 2600 E. Hoffman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine M. Hofferbert

6 DATE OF BIRTH (month, day, and year) Jan 9, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	10	17	

* OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Hofferbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Lingelbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Hofferbert

(Address) 2600 E. Hoffman St

15 Filed NOV 28 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to His death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. S. Hatem, M. D. Coroner

Nov 28 1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec. 1 1930

20 UNDERTAKER John Merrick

ADDRESS 200 Orleans

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62743

CERTIFICATE OF DEATH

188-203 E 62743

1-PLACE OF DEATH
City of Baltimore: (No. Balto City Hosp St., 26-39 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Stephen Burns

(a) RESIDENCE NO. Eastern Ave & Sewer Rd St., Ward 108 N Kenwood Ave
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie E Burns

6 DATE OF BIRTH (month, day, and year) 3/5/1891

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39	9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work R R
(b) General nature of industry, business, or establishment in which employed (or employer) Engineer
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm E Burns

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Cath. Spink

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Bessie E Burns
(Address) Eastern Ave & Sewer road

15 Filed 19 C. HUTZLER JONES, M.D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by a moving auto while walking along road

(a) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eastern Ave & Sewer Rd

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis? Clinical

(Signed) C J Trautman, M. D.

11-28-1930 (Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Angle Hill Cem Havre de Grace Md — DATE OF BURIAL Nov 29 1930

20 UNDERTAKER John Ulrich — ADDRESS 228 E Lanvale

Spec.—1-30—M. & T.—250 Bks

E 62744 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 62744

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 3-S)

CITY OF BALTIMORE: (NO. ST. WARD)

2-FULL NAME Dominic Ferri

(a) RESIDENCE NO. 241 Albemarle st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Ferri

DATE OF BIRTH (month, day, and year) Nov. 6, 1897

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33		19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Joseph Ferri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Ferri

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Hospital Records

(Address)

Filed 12 28 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 28, 1930, to Nov. 25, 1930, that I last saw him alive on Nov. 25, 1930, and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Penner, M. D.

11-25, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Nov 27 1930

20 UNDERTAKER Tendall & Lippel

ADDRESS 300 N Eden

Spec.—1-10-21—M&T—1500 Blks.

62745

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 62745

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1727 Orleans ST. 64 (WARD)

2-FULL NAME Amanda S. Tolliver

(a) RESIDENCE NO. 1727 Orleans St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	64	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER Isiah Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lula Proctor (Address) Curtis Bay

15 Filed ..... 19 ..... Registrar

JAN 23 1930 BALTIMORE, MD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1930 to 26 Nov 1930

that I last saw her alive on 22 Nov 1930

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Oedema of Extremities

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Robt Boyden M. D.

, 19 (Address) 1904 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 11-29 1930

20 UNDERTAKER Jno J. G. Socks

ADDRESS 1302 Jefferson

ec.—2-29-28—L. F. S.—500 Bks.

E 62746

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 46 ✓ E 62746

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 90 Augusta St. 10-14 (WARD)

2—FULL NAME Sr. M. Aveline Schmitt

(a) RESIDENCE NO. Convent of Notre Dame ST., WARD N.Y.
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 29, 1863

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	1	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Rochester N. Y.

10 NAME OF FATHER Andrew Schmitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agnes Bischof

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Sister of Notre Dame

(Address)

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1930, to November 27, 1930, that I last saw h Wx alive on November 27, 1930 and that death occurred, on the date stated above, at 5.40 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma ovary
with Abdominal Metastases

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 29 30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F J Sterly, M. D.

27, 1930 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Md. DATE OF BURIAL Nov. 29 1930

20 UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay St

pec.—1-30—M. & T.—250 Bks

62747

HEALTH DEPARTMENT—CITY OF BALTIMORE

160 E 62747

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST., 15-23 WARD

2-FULL NAME Elizabeth Johnson

(a) RESIDENCE NO. 1311 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Infant

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Elizabeth Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Elizabeth Gray

(Address) 1314 N Caroline St

Filed Nov 28 1930, 19 Registrar

C. HAMILTON JONES, M. D.

5295

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930, to Nov 27, 1930, that I last saw h alive on Nov 27, 1930, and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. Stanes, M. D.

11/28, 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND NOV 25 1930 Commissioner Health

Spec.—1-30—M. & T.—250 Bks

E 62748

E 62748

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. 4-25 ST. / WARD)

2-FULL NAME Harriett Clark

(a) RESIDENCE NO. 610 Fairmount ave. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Mch. 7, 1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	7	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) West River

(State or country) Maryland

10 NAME OF FATHER Joe Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Georganna ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

Informant Hospital Records

(Address)

Dec 19 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 19 30, to Nov. 23, 19 30,

that I last saw her alive on Nov. 23, 19 30,

and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) David Seiner, M. D.

11-24 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M. D.

Commissioner Health

UNIVERSITY OF MARYLAND

NOV 29 1930

Spec.—1-30—M. & T.—250 Bks

E 62749

E 62749

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 4-7 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jasper

(a) RESIDENCE NO. 613 E. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced (or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Richmond Va.

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of

(Address) Balto. City Hosp.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

5222

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25-30

17 I HEREBY CERTIFY, That I attended deceased from 9-13-30, 19..., to 11-25-30, 19...,

that I last saw him alive on 11-25-30, 19...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? 1 hour 2. hospital

Did an operation precede death? no Date of ...

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padgett, M. D.

11-26, 19... (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19...

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
NOV 26 1930

Commissioner Health

Spec.—1-30—M. & T.—250 Bks

E 62750 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62750

129

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 5-8 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Armstrong

(a) RESIDENCE NO. 503 Fapp St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Armstrong

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Henry Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Carolyn ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of

(Address) Balto. City Hosp.

Filed 15223 19 Dec 1 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-30

17 I HEREBY CERTIFY, That I attended deceased from 11-19-30, 19 to 11-22-30, 19, that I last saw him alive on 11-22-30, and that death occurred, on the date stated above, at 11:55 A.m.

The CAUSE OF DEATH* was as follows:

Nephritis, Subacute

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Uraemia, acute

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? In Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam; lab.

(Signed) Paul Padget, M. D.

11-26, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL NOV 2[illegible] 1930

20 UNDERTAKER

ADDRESS

C. HARRISON JONES, M. D. Commissioner Health

Spec.—1-30—M. & T.—250 Bks

62751

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 62751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 8-16

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Purthy

(a) RESIDENCE NO. 2121 Lewellyn Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

DATE OF BIRTH (month, day, and year) Dec. 7, 1876

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	11	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) St. Mary's Co. Md.

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of

(Address) Balto. City Hosp.

Filed ..... 19 ..... Registrar

3221

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23-30

17

I HEREBY CERTIFY, That I attended deceased from 9-24-30, 19 ..., to 11-23-30, 19 ...,

that I last saw him alive on 11-23-30, 19 ...,

and that death occurred, on the date stated above, at 1:20 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency

(duration) ... yrs. 9 mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic.

(duration) ... yrs. 9 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam. Wassermann

(Signed) Paul Padget, M. D.

11. 26. 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL ... 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
C. HARRISON JONES, M. D.
Commissioner Health
NOV 26 1930

26 1930

Spec.—1-30—M. & T.—250 Bks

E 62752 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62752

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 4-16 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Harris

(a) RESIDENCE NO. 721 Saratoga St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

a If married, widowed, or divorced HUSBAND of or) WIFE of Rose Harris

DATE OF BIRTH (month, day, and year) Dec. 17, 1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	3	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wise Bros.

BIRTHPLACE (city or town) (State or country) St. Mary's Co. Md.

10 NAME OF FATHER Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER Eliza Coler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co. Md.

Informant Records of

(Address) B-lto. City Hosp.

Filed 5220 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23-30

17 I HEREBY CERTIFY, That I attended deceased from 11-15-30, 19..., to 11-23-30, 19..., that I last saw him alive on 11-23-30, 19..., and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, with oedema

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Uraemia, chronic

(duration) ... yrs. ... mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam. lab.

(Signed) Paul Paget, M. D.

Dec. 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
Commissioner Health
NOV 28 1930

Spec.—1-30—M. & T.—250 Bks

E 62753

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62753

161-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 25-26 WARD)

2-FULL NAME Baby Boy Miller

(a) RESIDENCE NO. 3800 English Council Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of not married

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or ..... min.
	—	—	4 hrs	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Albert Charles Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Minnie Dalzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Toronto Canada

Informant .....
(Address) .....

Filed ..... 19 ..... Registrar

5218

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1930, to Nov. 26, 1930, that I last saw him alive on Nov. 26, 1930, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity
Baby about 34 weeks development.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) None (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) M. B. Schreiber M. D., M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

C. HAMPSON
Commissioner Health.
NOV 28 1930

Spec.—1-12-23—M&T—500 Bks.

E 62754

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62754

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 N Wolfe ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Logan

(a) RESIDENCE NO. 818 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucillen Logan

6 DATE OF BIRTH (month, day, and year): Mar. 7. 1873

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	37	8	18	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: A. Warshauer

8 BIRTHPLACE (city or town) (State or country): Buckingham Va

10 NAME OF FATHER: Hamin Logan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Jennie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: Lucillen Logan

(Address): 818 N Wolfe St

Filed 12 1930, 19

C. HARRISON JONES, M. D.

RRK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 25 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1930. to Nov 25. 1930.

that I last saw him alive on Nov 20. 1930.

and that death occurred, on the date stated above, at 7 10/17 m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary): Acute Dilatation Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Calvin B LeCompte, M. D.

, 19 (Address) 1113 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cemetery — DATE OF BURIAL: Nov. 29 1930

20 UNDERTAKER: P. D. Williams — ADDRESS: 1015 McCulloh St

1-30—M. & T.—100 B—50L

E 62755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62755

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 W. Hill St. ST. 22-31 WARD)

2-FULL NAME Charles Foster.(C)

(a) RESIDENCE NO. 229 W. Hill St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Dora Foster.(C)

6 DATE OF BIRTH (month, day, and year) December 25, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know.

14 Informant: Dora Foster.(C) wife.

(Address) 216 S. Dallas St.

15 Filed ..., 1930 ..., 192 ... Registrar

C. HEMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 26° 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Oh. M. Hemsley, Coroner, M. D.

11/28 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Nov 28 1930

UNDERTAKER: E. V. Gillespie

ADDRESS: 1515 McCulloh

Spec.—1-10-21—M&T—1500 Bks.

62756

HEALTH DEPARTMENT—CITY OF BALTIMORE

F. 62756

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2311 Callow Ave (St.) 12-54 (WARD)

2-FULL NAME Mrs. Annie B. Wilcox

(a) RESIDENCE NO. 2311 Callow Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Charles R. Wilcox

6 DATE OF BIRTH (month, day, and year) March 2-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Cramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Jane G Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo. Wilcox (Son) (Address) 4006 Liberty Rd.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1930, to Nov 26, 1930.

that I last saw h[illegible] alive on Nov 24, 1930

and that death occurred, on the date stated above, at [illegible] m.

THE CAUSE OF DEATH* was as follows:

Myocarditis.

Chr. nephritis with hypertension

Arteriosclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount — DATE OF BURIAL Nov. 29 1930

20 UNDERTAKER Robert L. Little — ADDRESS 2700 Edmondson Ave.

Spec—9-30—A & Co.—250 Bks

E 62757 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62757

CERTIFICATE OF DEATH. 179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1141 Hanover St. 21-29 WARD

2 FULL NAME Wm E. Dixon

(a) RESIDENCE NO. 1141 Hanover St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Dixon

6 DATE OF BIRTH (month, day, and year) Apr 29 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Wm E. Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary V. Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Mary V Dixon
(Address) 1141 Hanover St

15 Filed 1930, 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27-30

17

I HEREBY CERTIFY, That I attended deceased from Nov. 19 28, to Nov. 27, 19 30

that I last saw him alive on Nov. 27, 19 30 11 00 m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Skeen M. D.

11/28 1930 (Address) 122 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 29 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Blks

Dr Geo H. Hosking 5835 York Rd Tuc 0037

E 62758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 E 62758

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 446 Roseback Ave ST. 27-48 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Emery Disney

(a) RESIDENCE NO. 446 Rosebank Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, ~~widowed, or divorced~~ HUSBAND of ~~or) WIFE of~~ Mary Ellen Disney

DATE OF BIRTH (month, day, and year) Jan 26th 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	10	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter & D

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer Self

BIRTHPLACE (city or town) Balto (State or country) md

10 NAME OF FATHER O. M. Disney

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

Informant Oliver D Disney

(Address) 446 Rosebank Ave

Filed 1930 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1930 to Nov 27 1930, that I last saw him alive on Nov 26 1930, and that death occurred, on the date stated above, at 7.04 a.m.

The CAUSE OF DEATH* was as follows:

Ca tonsil-septic

Coroner John B Mowell

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo C Oliver MD, M. D.

, 19 (Address) 5835 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetary

DATE OF BURIAL 11/29/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 62759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 62759

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 N. Washington ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Smith

(a) RESIDENCE NO. 500 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas G. Smith

DATE OF BIRTH (month, day, and year) March 2 / 1888

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER John Schmitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Mary Asch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

Informant Thomas G. Smith

(Address) 500 N Wash. st

C. HAMPSON JONES, M. D.

1930 By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to Nov 25, 1930

that I last saw h-r alive on Nov. 25, 1930

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Rectal-Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Hemorrhoidectomy Date of Oct 8. 1930

Was there an autopsy? no

What test confirmed diagnosis? Biopsy of Cervix

(Signed) John F. Oliver, M. D.

Nov 28 1930 (Address) 26 E Preston st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Nov. 29 1930

20 UNDERTAKER Jos. J. Burr ADDRESS 156 N. Luzerne ave.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62760 × 49 E 62760

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 144 N.Collington Ave. ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clayshia Odell Willis

(a) RESIDENCE NO. 144 N.Collington Ave ST., WARD Cape Charles Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 8.1917

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	5	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Cape Charles Va.

10 NAME OF FATHER Linwood Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cape Charles Va.

12 MAIDEN NAME OF MOTHER Alice O.Nottingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cape Charles Va.

Informant Linwood Willis

(Address) 144 N.Collington Ave.

Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov.28.1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1930, to Nov 27, 1930,

that I last saw her alive on Nov 27, 1930

and that death occurred, on the date stated above, at 5:30A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas A Schaefer, M. D.

11/27, 1930 (Address) 2903 Echodale Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocomoke City, Md.

DATE OF BURIAL Nov 29, 1930

20 UNDERTAKER Hughes & Jones Inc

ADDRESS 424 N. Broadway

8 1930

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62761

90 E 62761

CERTIFICATE OF DEATH.

72-31

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 820 Sharp St. ____ Ward)

2-FULL NAME Sinclair Toye

(a) RESIDENCE NO. 820 Sharp St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 25 1877

AGE 53 Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
53	11	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Steamship industry

(c) Name of employer Clyde Line

BIRTHPLACE (city or town) ____

(State or country) Col. Co., Md.

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) (?)

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) (?)

14 Informant Sarah Walker

(Address) 820 Sharp St

Filed ____, 19____ Registrar ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/6/30, 1930, to 11/26, 1930, that I last saw h[illegible] alive on 11/26, 1930, and that death occurred, on the date stated above, at 2.59 p.m.

The CAUSE OF DEATH* was as follows:

Acute Aortic Regurgitation

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Acute Carditis 3 hrs

Dilation (duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted ___

If not at place of death? ___

Did an operation precede death? no Date of ___

Was there an autopsy? no

What test confirmed diagnosis? usual signs

(Signed) W. H. Carroll, M. D.

11/27 1930 (Address) 830 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Cemetery Nov 29 1930

Date of Burial

20 UNDERTAKER Walter B. Sprigg

ADDRESS 1390 W Hamburg St

1930 AKH

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62762 — 129 E 62762

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2937 St. Paul ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clement S. Ucker

(a) RESIDENCE NO. 2937 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs.— mos.— ds. How long in U. S., if foreign birth? — yrs.— mos.— ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Kathleen K. Clanchy

DATE OF BIRTH (month, day, and year) Oct. 14, 1873

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54	57	11	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Investment - Banker

(b) General nature of industry, business, or establishment in which employed (or employer) Ret

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ohio

10 NAME OF FATHER Samuel Ucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER ----- Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

Informant Mrs. Kathleen K. Ucker

(Address) 2937 St. Paul Street

C. HAMPSON JONES, M. D. Registrar

Filed 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 28 - 1930, to Nov 28, 1930, that I last saw h in alive on 8.45 a.m. 11/28 1930 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage due to Hypertension & coronary Sclerosis Hemiplegia (duration) — yrs.— mos. 3 hours ds.

CONTRIBUTORY (Secondary) Chronic Syphilitis (duration) Unknown

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jefferies Buck M. D.

11/28 1930 (Address) 5 Club Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington Mt. Olivet Cemetery D. C.

DATE OF BURIAL 12/1 1930

20 UNDERTAKER Henry W. Myers and Son

ADDRESS 805 N. Calvert

Spec.—1-30—M. & T.—250 Bks.

E 62763 HEALTH DEPARTMENT—CITY OF BALTIMORE 29 E 62763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore General Hospital REGISTERED NO. 25-32

CITY OF BALTIMORE: (No. ST. WARD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Petit (Pettit)

(a) RESIDENCE No. 2308 Annapolis Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Jennie Petit

DATE OF BIRTH (month, day, and year) August 14, 1875

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	3	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Millville, New Jersey

10 NAME OF FATHER Joseph Petit

11 BIRTHPLACE OF FATHER (city or town) (State or country) United States

12 MAIDEN NAME OF MOTHER Harriet Woolford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) United States

Informant Mrs. Jennie Pettit

(Address) 2308 Annapolis Road

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28-30

17 I HEREBY CERTIFY, That I attended deceased from November 26, 1930 to November 28, 1930, that I last saw him alive on November 28, 1930, and that death occurred, on the date stated above, at 7 45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic pancarditis, (cardiovascular-renal disease)

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) acute right cardiac dilatation (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy + clinical record

(Signed) Joseph N. Laurentaitis, M. D.

, 19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Millville, N. J.

DATE OF BURIAL 12/30 1930

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

Spec.—P-30—A. & Co.—250 Bks.

E 62764 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62764

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Kossuth ST. 10-10 WARD)

2 FULL NAME Margaret A. Goodman

(a) RESIDENCE NO. 122 Kossuth ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Goodman

6 DATE OF BIRTH (month, day, and year) Oct 18 45

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) House wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md

10 NAME OF FATHER John R Hadaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs H. M. St. Johnson (Address) 122 Kossuth St

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1930

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1928, to Nov 28, 1930.

that I last saw her alive on Nov 27, 1930.

and that death occurred, on the date stated above, at 3.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Diabetes

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Hoppe Johnson M. D.

, 19.. (Address) 2200 Frederick Ave Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Kent Co. Md Via Tolchester Co.

DATE OF BURIAL Nov 29 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Eight St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62765

CERTIFICATE OF DEATH

90 E 62765

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 W Barrie ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mable H Jenkins

(a) RESIDENCE NO. 630 W Barrie ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1890

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N. C.

10 NAME OF FATHER James Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Ella Whitaca

13 BIRTHPLACE OF MOTHER (city or town) (State or country) No

Informant Susie Griffin

(Address) 630 W. Barrie

Filed ..... 29 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 29 19 30, to Nov 26 19 30,

that I last saw h[illegible] alive on Nov 25 19 30

and that death occurred, on the date stated above, at 2 50 p m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 0 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) 0 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) J Edward Fisher, M. D.

11-28 19 30 (Address) 1612 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Catonsville N. C. DATE OF BURIAL Nov 29 19 30

20 UNDERTAKER Edward Hensley ADDRESS 1 W Biddle St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62766

CERTIFICATE OF DEATH

1930 E 62766

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Franklin Square Hospital 15-56 (Ward)

2-FULL NAME Iola Read Marsh

(a) RESIDENCE NO. 2904 Kate Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gorman Marsh

6 DATE OF BIRTH (month, day, and year) December 30, 1908

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	21	10	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS.

10 NAME OF FATHER J. Robert Read

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edith Enson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mrs. Edith Read the Same 3206 E. 20

9 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage, following criminal abortion produced by one unknown

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. W. Brooke, M. D.

Nov 27 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Faith Pres. Cemetery	Nov 29 1930
20 UNDERTAKER E. LeRoy Steffler, Inc	ADDRESS 1218 E North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62767 — 90 — Dr. Hager — E 62767

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 641 S. Eutaw ST., 1 WARD)

2—FULL NAME Peter Charles Johnson

(a) RESIDENCE NO. 641 S. Eutaw ST., 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 1 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie A. Johnson

DATE OF BIRTH (month, day, and year) Oct. 8th 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	46	1	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B. O. R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) Marine Dept.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Peter Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Braunschweiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Minnie A. Johnson

(Address) 641 S. Eutaw St.

DATE 1930 — C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1930, to Nov 25, 1930,

that I last saw h~~im~~ alive on Nov 25, 1930

and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. S. Hagner, M. D.

11/27/30 (Address) 2612 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Nov 29th 1930

20 UNDERTAKER: Lilly & Sons — ADDRESS: 1033 S. Wolfe St

20—M. & T.—100 B.—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

180-001 C
E 62768

E 62768

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced Dead at 10-7 ST. ..... WARD)

CITY OF BALTIMORE: (NO. Balto City Hospital

2-FULL NAME Cecil G Pretty

(a) RESIDENCE NO 3234 Foster ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 6 1930

AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	0	5	20	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Balto City
(State or country) Md

10 NAME OF FATHER Thomas G Pretty

11 BIRTHPLACE OF FATHER (city or town) Chicago
(State or country)

12 MAIDEN NAME OF MOTHER Jessie R Evans

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country) Md

Informant Thomas G. Pretty

(Address) 3234 Foster Ave

Filed 12-2 1930 C. HAMPSON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1930

17! I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental Suffocation
By turning in his Crib
On his face & could not return
to his back (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Ewen, M. D.
Coroner

11 27 1930 (Address) 700 Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 11/24/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

1-30—M & T—100 B—50L

E 62769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62769

170

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1645 Normal ST. 8-45 WARD)

2-FULL NAME Carmelo Carpita

(a) RESIDENCE NO 1645 Normal ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 45-48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Sewer Dept. Balto. City.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER George Carpita

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Barbara ------

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Charles Barbara
(Address) 820 N. Montford Ave

15 Filed ..... 192 ..... Registrar

C. HAMPSON JONES M. D.

C 1920

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage- Pistol shot in abdomen
Suicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Melancholia-Probably
ill health. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? yesby Dr. McCleary

What test confirmed diagnosis?

(Signed) ..... Coroner, M. D.

Nov 28/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Sepulchre Cem

DATE OF BURIAL 12/1/30 19

20 UNDERTAKER Geo. J. Smith Co.

ADDRESS 1135 Harford

1-30—M. & T.—100 B—50L

E 62770

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 E 62770

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Laurens ST. 16-27 WARD)

2-FULL NAME John R Jackson

(a) RESIDENCE NO. 1217 Laurens ST., ... WARD

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Madena Jackson

6 DATE OF BIRTH (month, day, and year) Mar. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Richard Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Samuel Wallace

(Address) 1021 N Calhoun St

15 Nov 1930 192 C. HUMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F Lyon, M. D.

Coroner

, 19 (Address) 1438 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Nov 29 1930

20 UNDERTAKER Thomas E Kelson

ADDRESS 1303 Presstman

1-30—M. & T.—100 B—50L

E 62771

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 E 62771

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 McElderry ST. 5-8 WARD)

2-FULL NAME William Thompson

(a) RESIDENCE NO 1214 McElderry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	blac k	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elkon, N.C.

PARENTS

10 NAME OF FATHER Lace Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Laura-----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Laura Thompson (Address) 1214 McElderry St

15 Filed 9 1930, 192 Wet [illegible] Registrar C. HAMPSON JONES, M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Tubercular Peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? at Hopkins July/30

(Signed) [signature] Coroner, M. D.

11/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 11-30 19 30

20 UNDERTAKER Byron & Knight 1218 N. Eden St

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 62772

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62772

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 207 Arsquith ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ford Carmack

(a) RESIDENCE NO. 207 Arsquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred R yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

If married, widowed, or divorced (HUSBAND) of or) WIFE of Helen Carmack

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto, Md

10 NAME OF FATHER Louis Carmack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

Informant Sterling Carmack

(Address) 1864 7th Ave New York City

Filed 1930 H. HANPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 3/30, to Nov 27/30, 19 30

that I last saw h alive on Nov 27/30, 19 30

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

several months

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) E. M. Doyle M. D.

Nov 29 1930 (Address) 119 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem.

DATE OF BURIAL 11-30 1930

20 UNDERTAKER Byron Wright 218 N Calvert St

ADDRESS

Spec.—1-30—M. & T.—250 Blks

E 62773 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 62773

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 26-37 ST., E. WARD)

2-FULL NAME Frank Podgoraki

(a) RESIDENCE NO. ? ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1845

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) NO

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland - Austria

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of

(Address) Balto. City Hosp.

Filed ... 19 ... Registrar

1930 C. HARRISON [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-30

17 I HEREBY CERTIFY, That I attended deceased from 11-16-15, 19 ... to 11-27-30, 19 ..., that I last saw him alive on 11-27-30, 19 ..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Senility, ~~Cancer of~~ Arteriosclerosis

Heart Disease, Arteriosclerotic

Unknown (duration) yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Thos. Glenn Dodd Jr M. D.

19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 11-29, 1930

20 UNDERTAKER J. J. Labay & Son

ADDRESS 1318 Light St.

Spec.—1-30—M. & T.—250 Bks

E 62774 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62774

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 26-37 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Timothy Morgan

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) April 9, 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gen

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Patrick Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Maria Leiden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Records of

(Address) Balto. City Hospitals

Filed ....., 19 ..... C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-30

17 I HEREBY CERTIFY, That I attended deceased from 12-6-28, 19..., to 11-27-30, 19...,

that I last saw him alive on 11-27-30, 19...,

and that death occurred, on the date stated above, at 6:40 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

Syphilis Aorta &

Aortic Insufficiency, Syphilis Testes

more than 4 years yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Gilmore Jr., M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 11-29 1930

20 UNDERTAKER J. J. Zabytowns

ADDRESS 1318 Eutaw St

Spec. 2-29-28—L. F. S.—500 Bks.

E 62775

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62775

CERTIFICATE OF DEATH

REGISTERED NO. 28-65 167

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4314 Flowerton Road ST. 28 WARD)

2—FULL NAME Roger Garland Clark

(a) RESIDENCE NO. 4314 Flowerton Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

DATE OF BIRTH (month, day, and year) Nov. 25, 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Robert L. Clark

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie Wolf

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Mr. Robert L. Clark
(Address) 4314 Flowerton Road

Filed 1930, 19 RRM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1930, to Nov 26, 1930, that I last saw him alive on Nov 25, 1930, and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity of Size (Twin)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Dr. Wissig, M. D.

Nov 24 1930 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Dec 1st 1930

20 UNDERTAKER Jos H B Cook

ADDRESS 1003 West Baltimore St

E 62776

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

V 74 - E 62776

REGISTERED NO. C .....

1. PLACE OF DEATH

CITY OF BALTIMORE (No 1634 St Paul 12-19 ST. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME George E. Lockard.

(Residence in Baltimore: No. 1639 St. Paul Street St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: December 5. (Month) (Day), 1852 (Year)

7. AGE: 77 yrs. 11 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer): Retired Railway Mail Clerk

9. BIRTHPLACE (State or country): Carroll Co., Md.

PARENTS

10. NAME OF FATHER: James Lockard

11. BIRTHPLACE OF FATHER (State or country): Carroll Co., Md.

12. MAIDEN NAME OF MOTHER: Rosean Mathias

13. BIRTHPLACE OF MOTHER (State or country): Frederick Co, m Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Marian Lockard

(Address) 2925 N. Charles Street.

15. DATE RECEIVED: V 29 1930

C. HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1927, to Nov 28 1930 that I saw him alive on Nov 27, 1930. and that death occurred on the date stated above. at 4 45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

Right Hemiplegia (3yrs).

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Cerebral Hemorrhage - 10 days

Terminal Broncho-Pneumonia - 3d

(Duration) mos. ds.

(Signed) Carroll Lockard M. D.

Nov 28, 1930 (Address) 4 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Nov 29 1930

20. UNDERTAKER: [illegible] Routson

ADDRESS: 2238 N Mon

Spec.—1-30—M. & T.—250 Bks

E 62777 HEALTH DEPARTMENT—CITY OF BALTIMORE E/62777

90V

CERTIFICATE OF DEATH.

REGISTERED NO. 28-63

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4106 Groveland Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casper J. Muth

(a) RESIDENCE NO. 4106 Groveland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Clara Muth

DATE OF BIRTH (month, day, and year) July 26-1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	4	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Eugene S. Muth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

Informant Clara S. Muth

(Address) 4106 Groveland Ave

Filed ....., 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26-1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1928 to Nov 26, 1930, that I last saw him alive on Nov 26, 1930, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH was as follows: *

Mitral Insufficiency

(duration) 1 yrs. 8 mos 25 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Blaugh, M. D.

Nov 26, 1930 (Address) 701 West N Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Ridge Cemetery

DATE OF BURIAL Nov 29 1930

20 UNDERTAKER H. S. Feldmeier Sons

ADDRESS North Ave

Spec.—1-30—M. & T.—250 Bks

E 62778

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62778

CERTIFICATE OF DEATH.

X 100-001

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 4-7 WARD)

2-FULL NAME Father Joseph Hessen

(a) RESIDENCE NO. Snow Shoe Penn ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of ✓

DATE OF BIRTH (month, day, and year) Aug 10. 1897

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33.	3	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Altona P.a.

10 NAME OF FATHER Matthew Hessen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Cath. O'malley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

Informant Hospital Records
(Address)

Filed 9 1930 . 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 . 1930 . to Nov 29 . 1930.

that I last saw him alive on Nov 29. . 1930.

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) C. M. Baumgardner, M. D.

. 19 (Address) Mercy Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Altona Pa

DATE OF BURIAL Dec 2 19 30

20 UNDERTAKER Wm J Lambert Altoona

ADDRESS 2 Pa Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 62779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 62779

REGISTERED NO. 16-69

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2444 Edmondson Ave. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophie Martin Kerin

(a) RESIDENCE NO. 2444 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	W -	Widowed.

If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John H. Kerin

DATE OF BIRTH (month, day, and year) Sept 13-1857

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73.	2	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Benjamin Talbott.

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah V. Martin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

Informant Violet K. Mayer.

(Address) 2444 Edmondson ave.

© 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 5- 1930, to 11-27- 1930, that I last saw h~~er~~ alive on November 27- 1930 and that death occurred, on the date stated above, at 12:00 Noon

The CAUSE OF DEATH* was as follows:

Caranoma of right breast and Stomach

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Atrophic Cirrhosis of Liver (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1924

Was there an autopsy? no

What test confirmed diagnosis? physical Signs.

(Signed) Chester Ruland, M. D.

11-27-1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 12/1/1930

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

E 62780

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62780

124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 N. Dallas ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Green

(a) RESIDENCE NO. 116 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. Green

DATE OF BIRTH (month, day, and year) Mar. 15 1887

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	8	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 110

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Isaac Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Fannie Gibbons

(Address) 116 N. Dallas st

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1930, to Nov 27, 1930,

that I last saw her alive on Nov 26, 1930,

and that death occurred, on the date stated above, at 1-10 A. m.

The CAUSE OF DEATH* was as follows:

Suppurative Hepatitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

11-28, 1930 (Address) 1822 N. Bradst.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Cemetery

DATE OF BURIAL Nov 30, 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Eastlanday

Spec.—1-30—M. & T.—250 Bks.

62781 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 62781

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 1520 E. Eager ST., (WARD) 1-13

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura A. Gallagher

(a) RESIDENCE NO. 1520 E. Eager ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 57 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Patrick J. Gallagher

DATE OF BIRTH (month, day, and year) 8. 11, 1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	3	16	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeper
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: Charles Cope

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Ellen F. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Emmitsburg Md.

Informant: Patrick J. Gallagher
(Address) 1520 E. Eager

Filed DEC 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 27. 30.

17 I HEREBY CERTIFY, That I attended deceased from July 28. 19 30 to November 27 19 30
that I last saw her alive on November 27 19 30 4 P.M.
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Arteri-Sclerosis
Cerebral Hemorrhage (duration) yrs. mos ds.
CONTRIBUTORY (Secondary) (Hemiplegia) (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What tests confirmed diagnosis? Clinical
(Signed) Harlow A. Meyer M. D.
11/28. 1930 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec. 1 1930

20 UNDERTAKER: Martin Dakey & Sons — ADDRESS: 1827 W. North Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 62782 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62782

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Md. Gen. Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 11-24 ST. WARD)

2—FULL NAME Chester M. Cullison

(a) RESIDENCE NO. Upperco Md. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Cullison

DATE OF BIRTH (month, day, and year) April 8 1873

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57		7	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Co

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Co.

10 NAME OF FATHER John Wilson Cullison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Robbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Hospital Record.

(Address)

Filed 2-9 1930, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28-30

17 I HEREBY CERTIFY, That I attended deceased from 11-13, 1930, to 11-28-30, 19

that I last saw h alive on 11-28-30, 19

and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert H. Kenworthy M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hamstead Md

DATE OF BURIAL Dec 1 1930

20 UNDERTAKER Earl Clinton

ADDRESS Hamstead Md

Spec.—1-30—M. & T.—250 Bks.

E 62783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 62783

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. Sinai Hospital ST. 26-11 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine Ruth

(a) RESIDENCE NO. 3305 Philadelphia Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Ruth

DATE OF BIRTH (month, day, and year) Dec 13-1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	49	11	15	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER John Decker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co.

12 MAIDEN NAME OF MOTHER Florence Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Henry Ruth
(Address) 3305 Philadelphia Ave.

Filed ...., 19 .... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1930, to Nov. 28, 1930,
that I last saw h[illegible] alive on Nov. 28, 1930,
and that death occurred, on the date stated above, at 2:05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Empyema
Septicemia (Pneumococcus)
(duration) 0 yrs. 0 mos 13 ds.

CONTRIBUTORY (Secondary) Gastric ulcer (duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy; X-ray

(Signed) Milton B. Kirk, M. D.
(Address) Sinai Hospital
, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herb Dedeaux Co.

DATE OF BURIAL 12-1-1930

ADDRESS Jefferson

20 UNDERTAKER Mrs. E. Miller & Son 2334 Jefferson

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62784 E° 62784

CERTIFICATE OF DEATH.

100

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Meeker

(a) RESIDENCE NO. 710 S. Regester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) November 1852

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Lawrence Neushafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Records of Balto. City Hosp.

Filed 19 C. HAMPSON JONES, M. D. Registrar

© 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-30

17 I HEREBY CERTIFY, That I attended deceased from 3-12-29, 19 to 11-27-30, 19, that I last saw her alive on 11-27-30, 19, and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

1, Simplex arteriosclerosis

2 arteriosclerotic heart disease

(duration) unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Fred W. Ambrall, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Connel Family

DATE OF BURIAL Nov 29 1930

20 UNDERTAKER Jas C. Mullen & Son

ADDRESS 2334 E. Jeffer...

Spec.—1-10-21—M&T—1500 Bks.

E 62785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 179 E 62785

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 400 N. Schroeder ST. 16-76 (WARD)

2-FULL NAME Robert Fogle

(a) RESIDENCE NO. Nursery × Childs Hospt. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6, 27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Maryland

PARENTS

10 NAME OF FATHER Raymond Fogle

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Goldie Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Miss (Helen) Miller R.N.
(Address) N.C. Hospt.

15 Filed 1930 C. HARTSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1930, to Nov 28, 1930, that I last saw h[illegible] alive on Nov 29, 1930 and that death occurred, on the date stated above, at 9 25a m.

The CAUSE OF DEATH* was as follows:

Body Burn with hot water

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fredrick Blunt M. D.

, 19 (Address) 1031 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Locust Grove Fred Co	Nov 30 1930

20 UNDERTAKER ADDRESS

Powell & Albaugh Libertytown

Spec.—8-16-29—L. F. S.—100 Bks.

E 62786

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62786

CERTIFICATE OF DEATH

88

REGISTERED NO. 18-29

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1045 Hollins ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph B Mc Conville

(a) RESIDENCE NO. 1045 Hollins ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 5 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of the late Stella B Mc Conville

DATE OF BIRTH (month, day, and year) June 25th 1856

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	5	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Edward Mc Conville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Mc Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

Informant Mrs Geo Frank

(Address) 1045 Hollins St.

C. HAMPSON JONES, M. D.

1930 19 NCH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 20. 1930, to Nov. 27. 1930, that I last saw h[im] alive on Nov. 27. 1930 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart.
(Acute Myocarditis)

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Etc.

(Signed) Chas Horton, M. D.

12/ 1/ 1930 (Address) 888 N. Lemond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	12/ 1/ 1930
20 UNDERTAKER	ADDRESS
Coleman & Conway	901 Hollins St

Spec.—1-30—M. & T.—250 Bks.

E 742799 E 62787

HEALTH DEPARTMENT—CITY OF BALTIMORE E 62787

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 12-51 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME S-Thomas Nichols

(a) RESIDENCE NO. 2637 Bernard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Laura Virginia Nichols

DATE OF BIRTH (month, day, and year) Mar-17-1867

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) 057

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Friends

(Address) C. HANSON JONES, M. D.

Filed 1930 By Regiatrar 522

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-24-30

17

I HEREBY CERTIFY, That I attended deceased from Nov 19, 1930, to Nov 24, 1930, that I last saw h.im alive on Nov 24, 1930, and that death occurred, on the date stated above, at 11 27 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocardial Insufficiency

Auricular fibrillation

Congestive failure (duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic alcoholism (duration) 50 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) John W. Pearce, M. D.

11/24 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL NOV 2 1930

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner Health

30—M. & T.—100 B—50L

E 62788

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62788

CERTIFICATE OF DEATH

38

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 8-17 WARD)

2-FULL NAME James Cole

(a) RESIDENCE NO 1317 N. Dallas ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	black	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 29/1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	0	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Wm. Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Bessie Coles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Bessie Coles

(Address)

Filed NOV 28 1930, 19.. C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Congenital Syphillis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? Anatomy-Hopkins

What test confirmed diagnosis? .....

(Signed) [signature] M. D. Coroner

Nov 29/30 19.. (Address) 908 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL Nov. 29, 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1725 Ashland Ave

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 62789

CERTIFICATE OF DEATH

E 62789

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No.) 1605 E Madison ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abraham Trayham

(a) RESIDENCE NO. 1605 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Jenelle Trayham

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	45			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Thomas Trayham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Adeline Wade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Jenelle Trayham

(Address) 1605 E Madison

91930 C. HAMPSON JONES, M. D. Registrar

Filed ..., 19.. Dec 8

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1930, to Nov 27, 1930, that I last saw h.. alive on Nov 27-3, 1930 and that death occurred, on the date stated above, at 10 Pm m.

The CAUSE OF DEATH* was as follows:

Myocarditis Mitral Insufficiency

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

11-29 1930 Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery — DATE OF BURIAL Nov. 30 1930

20 UNDERTAKER Mrs R. G. Elliott — ADDRESS 1720 Eastlandale

Spec.—1-30—M. & T.—250 Bks.

24146
B 62790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 129 E 62790

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hawthorne

(a) RESIDENCE NO. Provincetown Mass ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Marion C Haw Thorne

DATE OF BIRTH (month, day, and year) 1/8/72.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	10	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) — 001

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Indiana

10 NAME OF FATHER Joseph Haw Thorne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Emeline Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

Informant JOHNS HOPKINS HOSPITAL (Address) Records.

Filed 25 1930 19 RK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-30

17 I HEREBY CERTIFY, That I attended deceased from 9-30-, 1930, to 11-29, 1930, that I last saw h[illegible] alive on 11-29, 1930, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows: chronic nephritis, hypertension

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) uremia, bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes autopsy

What test confirmed diagnosis?

(Signed) John Howard, M. D.

11/29 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York N.Y. DATE OF BURIAL Nov 29 1930

20 UNDERTAKER John C Mitchell & Sons. ADDRESS 1911 Eutaw Place

Spec.—1-10-21 M&T 1500 Bks.

E 62791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62791

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.) 2411 (ST.) Huron St. (WARD) 14-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Key

(a) RESIDENCE NO. 1411 (ST.) Druid Hill Av. (WARD) 14

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John W. Key

6 DATE OF BIRTH (month, day, and year): 5-10-1856

7 AGE: Years 74 Months 6 Days 16 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine Tasker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Catherine K. Shorts (Address) 2411 Huron St

15 [illegible] 30 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1930 to Nov 25 1930

that I last saw her alive on Nov 25 1930

and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

probably (duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) L. D. Hughes M. D.

(Address) 1413 D. Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Nov. 28 1930

20 UNDERTAKER: John McJohnson — ADDRESS 2331 Madison Av

Spec.—1-30—M. & T.—250 Bks

D. N. E. 3. Schubert 1403 Park Ave

62792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 E 62792

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 E. 25th St. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Estar Nash

(a) RESIDENCE NO. 415 E. 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) March 7th 1875

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	8	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto md

10 NAME OF FATHER Thos. E. Nash Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Catherine Willyard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

Informant Mrs May Nash

(Address) 524 E. 30th St

Filed Dec 2 1930 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to 11/29, 1930,

that I last saw h[illegible] alive on 11/29, 1930,

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis

(duration) Years mos da.

CONTRIBUTORY (Secondary) Occlusion of coronal left leg with ulcerating condition

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Dr. Schubert, M. D.

(Address) 1403 Park Ave 12/2, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 12/2/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

E 62793

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62793

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 835 West Barre ST. 21-29 (WARD)

2-FULL NAME John T. Goldwine

(a) RESIDENCE NO. 835 West Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced (HUSBAND of or) WIFE of Jennie Goldwine

DATE OF BIRTH (month, day, and year) July 16/83

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	4	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Basto City

(c) Name of employer Water Department

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John T. Goldwine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Sokatis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs Jennie Goldwine

(Address) 835 West Barre

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1929, to Nov 28, 1930, that I last saw h[illegible] alive on Nov. 28, 1930, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 11 mos 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John Strandowsky M. D.

12/9, 1930 (Address) 642 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 12/1 1930

20 UNDERTAKER William Cook

ADDRESS 1275 St Paul

Reg. JONES, M.

Spec.—1-30—M. & T.—250 Bks

Dr Vogle - 3042 Hudson St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62794

CERTIFICATE OF DEATH.

105 E 62794

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 S. Potomac ST. 1-1 WARD)

2-FULL NAME Minnie G Crowey

(a) RESIDENCE NO. 811 S. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Charles W. Crowey

DATE OF BIRTH (month, day, and year) May 2 1867

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	6	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Warren ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant John F. Crowey

(Address) 1911 Rosedale St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Nov. 28, 1930,

that I last saw h[illegible] alive on Nov 28, 1930,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) Chronic Bronchial asthma

(duration) 1 yrs. 1 mos. — da.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jas Vogle M. D.

11/29 1930 (Address) Jas Vogle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery

DATE OF BURIAL 12/1/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

E 62795 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62795

91-00

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1512 W Balto St, ST 19-27 WARD)

2-FULL NAME Isaac M. Batisky

(a) RESIDENCE NO. 1512 W. Balto. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of China Batisky

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Aaron Batisky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Zuba —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant J. Lewis (Address) 1439 E. Balto St

Filed 11/30/30 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30-30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1930, to Nov 30, 1930, that I last saw h[illegible] alive on Nov 28, 1930, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Edw V Cragin M. D.

11/30/30 (Address) 244 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Cemetery

DATE OF BURIAL 11-30 1930

20 UNDERTAKER Jack Lewis, 1439 E Balto St

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

Garfinkle ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62796 E 62796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Lenndale REGISTERED NO. 27-54-90

CITY OF BALTIMORE: (NO. ST. 27-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ida Garfinkle

(a) RESIDENCE NO. Lenndale Belvedere & Greenspring ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

BIRTHPLACE (City or town) (State or country) Russia

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

Informant Sigmund Garfinkle

(Address) Belvedere & Greenspring

Filed .19 Per C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28 1930

17

I HEREBY CERTIFY, That I attended deceased from 7-1 .19 30. to 11-28 .19 30.

that I last saw h[illegible] alive on 11-28 .19 30

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chr Card Vascular disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edmund Levin, M. D.

.19 (Address) Lenndale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levering Park DATE OF BURIAL 11-30 1930

20 UNDERTAKER Isaac Lewis, 1439 E Balto St ADDRESS

Spec.—1-30—M. & T.—250 Bks.

✓ E 62797

62797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Sinai Hospital ST., 15-58 WARD)
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Lebowitch

(a) RESIDENCE NO. 2710 Oswego Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Fannie Lebowitch

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Hungary
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

Informant J. Lewis
(Address) 1439 E Dale Ave

Filed ..... 19 .....

C. HARRY JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1930, to Nov. 28, 1930, that I last saw him alive on Nov. 28, 1930, and that death occurred, on the date stated above, at 3 0. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Obs.

(Signed) Milton B Kirsh, M. D.
, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lower Washington Road
DATE OF BURIAL 11 30 1930

20 UNDERTAKER Jacob Lewis, 1439 E Dale Ave
ADDRESS

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62798 ✓ 161-001 E 62798

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 15-58 WARD)

2-FULL NAME Baby girl Raiden Iturn

(a) RESIDENCE NO. 2532 Park Heights Terr ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 11/26/30

AGE	Years	Months	Days	If LESS than 1 day, 10 hrs. or min.
	1			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Mercy Hospital Baltimore, Md

10 NAME OF FATHER William Raiden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Celia Brens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

Informant Hospital Records

(Address)

Filed 19 H. J. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27/30

17 I HEREBY CERTIFY, That I attended deceased from 11/26, 1930, to 11/27, 1930, that I last saw her alive on 11/27, 1930, and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 10 hrs ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) J H Goodman, M. D.

11/28, 1930 (Address) Mercy Hospital Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Evergreen

DATE OF BURIAL 11-30 1930

20 UNDERTAKER Jack Levine

ADDRESS 1139 E Balto St

Spec.—1-30—M. & T.—250 Bks

Radin

E 62799

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62799

CERTIFICATE OF DEATH.

161

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital S. 15-58 WARD)

2-FULL NAME Baby Girl Radin

(a) RESIDENCE NO. 2432 Park Heights Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 dys, 2 hrs. ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

DATE OF BIRTH (month, day, and year) 11-26-30

AGE	Years	Months	Days	If LESS than 1 day 2 hrs. or ... min.
	hrs.		2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Mercy Hospital Baltimore Md.

10 NAME OF FATHER William Radin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Celia Press

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

Informant Next of kin
(Address)

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28-30

17 I HEREBY CERTIFY, That I attended deceased from 11/26, 1930, to 11/28, 1930, that I last saw h[illegible] alive on Nov. 28, 1930, and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) ✓ Twin Birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G. M. Baumgardner, M. D.

11/28 1930 (Address) Mercy Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Levy Jewish Rawing Run	11-30 1930
20 UNDERTAKER	ADDRESS
Jack Lewis	1739 E Balto St

ROGER HARRISON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

E 62800

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-102 62800

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) West Balto Ave St., 15-61 (Ward)

2-FULL NAME Enoch M Barker

(a) RESIDENCE NO. 207 Chelsea Terrace St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Caldwell

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day .... hrs. or .... min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Crawford
(State or country) N Y

PARENTS

10 NAME OF FATHER Geo E Barker

11 BIRTHPLACE OF FATHER (city or town) N Y
(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Rusher

13 BIRTHPLACE OF MOTHER (city or town) N Y
(State or country) N Y

14 Informant Ralph E Barker
(Address) Govans M D

15 Filed ..... 19.. C. H. ATKINSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & knocked down by a moving auto while crossing road
(a) Fract Skull (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio Sc (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hilton Virginia Mill

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) J. Evans M. D.

11/29, 1930 (Address) 2930 E Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	12/1/ 1930
20 UNDERTAKER	ADDRESS
Henry H Pearson	2058 N Calvert

NON

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62801 +9 E 62801

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 15-21 WARD)

2-FULL NAME Mrs. Sarah Schulman

(a) RESIDENCE NO. 1522 Appleton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 31 0

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Israel Bernstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ethel Silverman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Samuel Schulman
(Address) 1522 Appleton st

Filed 19 C. HAMPSON JONES, M. D. City Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1930, to Nov. 28, 1930, that I last saw her alive on Nov. 28th, 1930, and that death occurred, on the date stated above, at 9 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left kidney

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov. 13.

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Geo. J. Knapp, Jr., M. D.

11/28/1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herzog Run

DATE OF BURIAL Nov 30 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto st

OC ACN

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 62802

CERTIFICATE OF DEATH.

62802

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1802 N Mosher ST. 16-22 WARD)

2-FULL NAME John Himler

(a) RESIDENCE NO. 1802 N Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of E. Elizabeth Himler

DATE OF BIRTH (month, day, and year) Mar 10. 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	8	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Ice & Coal Dealer

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Westminster Md

10 NAME OF FATHER John Himler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Luther E. Himler

(Address) 5919 Edna ave

C-AONC HARRISON JONES, M. D.

Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 30 to Nov 28, 1930,

that I last saw him alive on Nov 27/30 19 7.25 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue —

1

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) D. J. Gray —, M. D.

12/29/30 (Address) 6 W N. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL Dec 1 1930

20 UNDERTAKER Mr & Mrs. John W. Teufel & Son

ADDRESS 801 W. Fayette St.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 62803 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62803

CERTIFICATE OF DEATH.

Registered No. 489

1-PLACE OF DEATH

City of BALTIMORE: (No. 936 E. Monument St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorenzo Dr. Emry

(a) Residence No. 936 E. Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Margaret A. Emry

6-DATE OF BIRTH (month, day and year) Feb. 6 1867

7-AGE 63 yrs. 9 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Crown Cork & Seal Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Carroll Co Md.

PARENTS.

10-NAME OF FATHER, William H Emry

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Lucia Beckinsale

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-Informant Mrs Maggie Emry

(Address) 936 E Monument St

Filed DEC 8 1930 J. HALLISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 28 1930

17- I HEREBY CERTIFY, That I attended deceased from Nov. 16 1930 to Nov. 28 1930.

that I last saw her alive on Nov. 28 1930,

and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A Veeh M. D.

11/29 1930 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Co. DATE OF BURIAL, Dec 1st 1930

20-UNDERTAKER. George Schaffer & Son ADDRESS 1126 E Monument St

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62804

E 62804

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2418 Montebello Terrace (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pizarro O'Connell

(a) RESIDENCE No. 2418 Montebello Terrace Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria J.

6 DATE OF BIRTH (month, day, and year) 3-2-'61 Mar. 2-1861

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Morgan College

(c) Name of employer

9 BIRTHPLACE (city or town) Miss.

(State or country)

PARENTS

10 NAME OF FATHER Richard O'Connell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Africa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Maria J. O'Connell

(Address) 2418 Montebello Terrace

15 Filed NOV 30 1930 19 C. HAMPTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 26-30 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 19 30 to Nov 26 19 30

that I last saw h alive on Nov 25 19 30

and that death occurred, on the date stated above, at 2.20 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis and Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 12 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) T. B. Hawkins M. D.

19 (Address) 1202 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Date of Burial 11/30/ 1930

UNDERTAKER Mrs. Geo. H. Holland ADDRESS 1631 Druid Hill

Spec.—1-30—M. & T.—250 Bks

62805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 60 E 62805

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 4-7 WARD)

2-FULL NAME Pearl Gimby

(a) RESIDENCE NO. Pocomoke Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	~~Single~~ Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of — David

DATE OF BIRTH (month, day, and year) Jan 6, 1907

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	10	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Pocomoke, Maryland.

10 NAME OF FATHER James Stevenson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Daisy Redden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant: Vernon T. Stevenson (Address) Pocomoke, Md.

Filed [redacted] 19 C. RALPH JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Nov 29, 1930, that I last saw h~~e~~r alive on ~~Sep~~ Nov 29, 1930, and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH* was as follows:

aberrant Thyroid Tumor

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Nov 22, 1930

Was there an autopsy? No

What test confirmed diagnosis? Biopsy of Tumor.

(Signed) J. Leyko, M. D.

11/29, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocomoke, Md.

DATE OF BURIAL 12/30/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 631 Druid Hill Ave

Spec.—1-30—M. & T.—250 Bks.

E 62806

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62806

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Wilkens & Caton Ave (Hospital) WARD 16-70

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno Henry Poffenberger

(a) RESIDENCE NO. 3430 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced HUSBAND of or) WIFE of Florence Poffenberger

DATE OF BIRTH (month, day, and year) January 24, 1891

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	10	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland Sharpsburg Md

10 NAME OF FATHER Geo H. Poffenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington Co Md

12 MAIDEN NAME OF MOTHER Willa Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington Co Md

Informant Mrs Florence Poffenberger

(Address) 3430 Edmondson Ave.

Filed C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1930, to Nov. 28, 1930, that I last saw h~~im~~alive on Nov. 28, 1930, and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

perforation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 11/22/30

Was there an autopsy? yes

What test confirmed diagnosis? Operation (Phys'cal Exam)

(Signed) Archibald R Purnell Jr M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sharpsburg Md

DATE OF BURIAL Dec 1st 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

1-30—M. & T.—100 B—50L

E 62807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

112 ✓ E 62807

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2317 Edmondson Av. (ST.) 70-64 (WARD)

2-FULL NAME Mary Montecavallo

(a) RESIDENCE NO 2400-Lauretta Av. ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Montecavallo

6 DATE OF BIRTH (month, day, and year) 2-11-1888

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
42	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Restaurant
(b) General nature of industry, business, or establishment in which employed (or employer) owner
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Michael De Angelo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Dominick Montecavallo

(Address) 2400-Lauretta Av.

15 [illegible] 1930 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis.

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic (duration) yrs. mos. 6 hrs.

18 Where was disease contracted if not at place of death? 428 Forrest St

Did an operation precede death? ..... Date of —

Was there an autopsy? —

What test confirmed diagnosis? Vision Exam

(Signed) H. C. Wade, M. D. Coroner

19 (Address) 1430 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Sepulchre

DATE OF BURIAL 12/1/30

20 UNDERTAKER George J. Pentz Inc

ADDRESS 1703 Hoffman St

Spec.—1-30—M. & T.—250 Bks

E 62808

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62808

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Hassan.

(a) RESIDENCE NO. 1601 N. Bond St. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Charles E. Hassan

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland Baltimore

10 NAME OF FATHER Charles Hattas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Liddle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Chas. Hassan

(Address) 1601 N. Bond St

Filed 19 T. THOMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29/30.

17 I HEREBY CERTIFY, That I attended deceased from 10/27, 1930, to 11/29, 1930,

that I last saw h[illegible] alive on 11/29, 1930

and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerular Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urin examination

(Signed) G. M. Baumgartner, M. D.

19 (Address) Mercy Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 12/1/30 19

20 UNDERTAKER Geo. J. Roth Inc

ADDRESS 1721 Harford

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62809

CERTIFICATE OF DEATH.

90 E 62809

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N. Bentalou ST. 16-68 WARD)

2-FULL NAME George I. Lawrence

(a) RESIDENCE NO. 8 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Welsh Lawrence

DATE OF BIRTH (month, day, and year) May 22 - 1864

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	6	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER George Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Virginia Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Edw. I. Lawrence

(Address) 9 N. Bentalou St.

30-1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28/30.

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 . 19 30 . to Nov 28 . 19 30.

that I last saw h[illegible] alive on Nov 28 . 19 30

and that death occurred, on the date stated above, at 8 00 A. m.

The CAUSE OF DEATH* was as follows:

Hypernephroid Neoplasm of Kidney.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) John A. Schweinitz, M. D.

19 (Address) 1337 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec. 1. 1930

UNDERTAKER: Margaret E. Flynn — ADDRESS: 142 Reg[illegible]

Spec.—1-30—M. & T.—250 Blks.

62810 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62810

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., East 0 WARD

2-FULL NAME George Starr

(a) RESIDENCE NO. 2881 Pelham ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of Single

DATE OF BIRTH (month, day, and year) Sept 28 1865

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	2	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Transfer Co 009

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Geo Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs Jennie Hudson

(Address) 2881 Pelham Ave

C. HAMPSON JONES, Registrar

7 30 1930 80 ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-22-30, 19..., to 11-30, 19 30, that I last saw h... alive on 11-30-30, 19..., and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Lawrence M. Sims, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 3, 1930
20 UNDERTAKER Elmer W Conklin	ADDRESS 924 E. Eager St

1-30—M. & T.—100 B—50L

62811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62811

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 831 Warner St. (St.) 21-31 (WARD)

2-FULL NAME Caroline Jennings.(C)

(a) RESIDENCE No. 831 Warner St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed or divorced (or) WIFE of Charles Jennings.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Peter Jennings.(C) son.

(Address) 162 N. West St.

15 Filed 1 1930 16 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) November 28, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) [illegible] M. D. Coroner

11/29/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Cemetery Dove

DATE OF BURIAL 1 1930

20 UNDERTAKER Wester & Spurrier 34 W Hamburg st

ADDRESS

1-30—M. & T.—100 B—50L

E 62812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-00

E 62812

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 620 N. Carlton ST. 18-26 WARD)

2-FULL NAME Wm Shipley

(a) RESIDENCE NO 620 N. Carlton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) May 17-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Virginia E. Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Orl. Md

14 Informant Virginia Shipley
(Address) 620 N. Carlton St

15 Filed Dec 1 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 29th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pneumococcus Type I

(Signed) ..... M. D.
Nov 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cemetery	Dec 1 1930
20 UNDERTAKER	ADDRESS 322 N
Mrs Katie R. Williams	Eutaw St

1-30—M. & T.—100 B—50L

E 62813

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002 E 62813

CERTIFICATE OF DEATH

REGISTERED NO. 16-33

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 917 N. Carroll St. (ST.) (WARD)

2-FULL NAME Floyd Gray

(a) RESIDENCE NO. 917 Carroll St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George S. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Viola Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Viola Gray

(Address) 917 Carroll St

15 Filed 1930 WILLIAM P. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] Coroner, M. D.

1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL Dec 1 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

Spec.—1-30—M. & T.—250 Bks.

24304 E 62814

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62814

× 153

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7-9 WARD)

2-FULL NAME Dorothy Biedenkapp

(a) RESIDENCE NO. Cypress Ave. Colgate ST. Md WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER William Biedenkapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marie Hesselberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Johns Hopkins Hospital

(Address) Depts

Filed ..... C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 29/30

17 I HEREBY CERTIFY, That I attended deceased from November 19 30 to November 29, 1930, that I last saw he alive on November 29, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cellulitis of face

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? In the home

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) J. C. Goodwin, M. D.

11/30, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Violetville St Paul

DATE OF BURIAL 12-4 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

pec.—1-30—M. & T.—250 Bks.

E 62815 HEALTH DEPARTMENT—CITY OF BALTIMORE ~~E 62815~~ E 62815

CERTIFICATE OF DEATH. REGISTERED NO. 129

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 4008 Falls Road ST., 13 WARD

2-FULL NAME Frank A. Norton

(a) RESIDENCE NO. 4008 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Lillian I. Norton

7 DATE OF BIRTH (month, day, and year) Feb. 14-1904

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER James A. Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Daisy M. Heath

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mrs. Lillian I. Norton

(Address) 4008 Falls Road

Filed Nov. 29 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept ..., 1930, to Nov 28, 1930, that I last saw him alive on Nov 28, 1930, 1.45 P. m. and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Elmer L. Levi M. D.

Nov. 29 1930 (Address) 800 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Dec. 2 1930.

A UNDERTAKER Horace A. Burgee ADDRESS 631 Falls Road

Spec.—1-30—M. & T.—250 Bks.

E 62816 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62816

E 62816

CERTIFICATE OF DEATH. 129

REGISTERED NO. 13557

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2070 Woodberry Ave ST., 13 WARD)

2-FULL NAME Thomas R. Bamber

(a) RESIDENCE NO. 2070 Woodberry Ave. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Frances L. Bamber

DATE OF BIRTH (month, day, and year) Nov. 10. 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	—	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

10 NAME OF FATHER Thomas L. Bamber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Disney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mrs. Frances L. Bamber

(Address) 2070 Woodberry Ave.

Filed 1930 HARRISON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27-1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 29 1929 to Nov 27 1930

that I last saw h live on Nov 27 1930

and that death occurred, on the date stated above, at 10 50 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr Valv. Heart. Arterio Sclerosis Chr Nephritis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) H. Wood M. D.

12/1 1930 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Dec. 1- 1930.

UNDERTAKER Horace F. Burgee

ADDRESS 3631 Falls Road

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62817

E 62817

CERTIFICATE OF DEATH.

89

E 62817

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) No. 3308 Egerton Place St. 15 WARD.

2-FULL NAME Charles F. W. Bornmann.

(a) RESIDENCE. No. 3308 Egerton Place St., 15 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Dora Bornmann

6 DATE OF BIRTH (month, day, and year) June 9. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md

10 NAME OF FATHER Christopher Bornmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Ella Dora Bornmann
(Address) 3308 Egerton Road

15 Filed 1 1930, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1930, to Nov 29, 1930, that I last saw him alive on Nov 29, 1930, and that death occurred, on the date stated above, at 10.45 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & hypertension (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms & physical examination

(Signed) Charles F Warner, M. D.

, 19 (Address) 3312 Egerton Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dames Cem. My Lady's Manor Balto Co.	Dec. 1 1930
20 UNDERTAKER Horace F. Burgee	ADDRESS 3631 Falls Road

Rec.—2-29-28—L. F. S.—500 Bks.

62818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 62818

E 62818

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 E. 39th St. 9-47 WARD)

2—FULL NAME Bertha Fraking

(a) RESIDENCE NO. 508 E. 39th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of William E. Fraking

DATE OF BIRTH (month, day, and year) Aug 11 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) House wife

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Frederick C Lindenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Wenke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs R. L. Dowell

(Address) 508 E 39th St

Filed 1930 . 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 13, 1930, to Nov 28, 1930,

that I last saw her alive on Nov. 28, 1930

and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Endocarditis

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Rheumatic Arthritis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H. G. Prentiss, M. D.

11-28-1930 (Address) 634 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Dec 1 1930

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62819

REGISTERED NO. E 62819

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. 1124 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Stingem

(a) RESIDENCE NO. Reisterstown, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced (or) WIFE of Jake Stingem

DATE OF BIRTH (month, day, and year) April 4, 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Howard Co., Md.

10 NAME OF FATHER Samuel Hanly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Ellicott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hospital Record.

(Address)

Filed 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1930, to Nov. 28, 1930, that I last saw h[illegible] alive on Nov. 28, 1930, and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism immediate

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Reisterstown, Md.

Did an operation precede death? Yes. Date of 11/24/30

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) John W. Chenault, M. D.

11/28, 1930 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Dec 1 1930

20 UNDERTAKER Henry W. Jenkins & Son

ADDRESS Oakland Mt. Lebanon Sts

Spec.—1-30—M. & T.—250 Bks.

62820

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 62820

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lyderham Hospital ST. 23-33 (WARD)

2-FULL NAME Estelle Amelia Oliver

(a) RESIDENCE NO. 1411 Patapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 10, 1928

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

10 NAME OF FATHER Charles Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Ullman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Md.

Informant Charles Oliver

(Address) 1411 Patapsco St.

Filed 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1930, to Nov. 29, 1930, that I last saw her alive on Nov 29, 1930, and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1411 Patapsco St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination (Physical)

(Signed) A. Peter Meranchuk, M. D.

, 19 (Address) Lyderham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C. A. Co.	12-1st 1930
20 UNDERTAKER E & B Harle 115	ADDRESS E West St

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 62821

E 62821

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 N.Gay St. ST., 5-4 WARD)

2-FULL NAME Joseph Mansfield.

(a) RESIDENCE NO 432 N.Front St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	About 60	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ship yard worker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Report. C.D.

(Address)

15 Filed 1 1930 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 25, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of a Aortic Aneurysm.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas. H. Bernard Coroner, M. D.

11/29/30 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C.A.Co

DATE OF BURIAL 12-1 1930

20 UNDERTAKER Bernard C Harde

ADDRESS 1005 N Paca St

Spec.—8-16-29—L. F. S.—100 Bks.

Joseph Johnson 1

B 62822

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 62822

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Brunt ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Johnson

(a) RESIDENCE NO. 1427 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

DATE OF BIRTH (month, day, and year) 1886

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	44	✓	✓	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ own

(c) Name of employer ✓

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Jacob or Joshua Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Solomon Johnson

(Address) 1427 Brunt St

Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29/30

17 I HEREBY CERTIFY, That I attended deceased from 11/8/30, 19..., to 11/24/30, 19..., that I last saw him alive on 11/24/30, 19..., and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Stomach trouble or ulcer

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Sputum

(Signed) A. H. Barksdale, M. D.

19 (Address) 524 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waverly Cemetery

DATE OF BURIAL Dec 1 1930

UNDERTAKER Virginia A Brooks

ADDRESS 1463 N. Carey

WM. H. JONES, M. D. Registrar

1 1930

Spec.—1-30—M. & T.—250 Bks

E 62823

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62823

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2422 W. Lafayette Ave (WARD)

2-FULL NAME Myrtle Elizabeth Lorenty

(a) RESIDENCE NO. 2422 W. Lafayette Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Single.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 4, 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dalto Peddlers Woods Milford N. Va

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Mercellus Lorenty

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mary Austin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Miss Virginia B. Lorenty

(Address) 2422 W. Lafayette Ave

Filed 1930 H. L. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1930, to Nov. 28, 1930, that I last saw h[illegible] alive on Nov. 28, 1930, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas C. Ford, M. D.

11-29, 1930 (Address) 235 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

20 UNDERTAKER Wm. J. Buckner Sons

DATE OF BURIAL Dec 1 1930

ADDRESS North & Fa

Spec.—2-20-28—L. F. S.—500 Bks.

E 62824

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62824

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3115 Leeds ST., 20-70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. Thomas

(a) RESIDENCE NO. 3115 Leeds ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: M | 4 COLOR OR RACE: C | 5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed or divorced HUSBAND of (or) WIFE of: Agnes Thomas

DATE OF BIRTH (month, day, and year): 1868

AGE: Years 62 | Months 10 | Days 4 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Landscaper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self Business

BIRTHPLACE (city or town) (State or country): North Point Md.

10 NAME OF FATHER: Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): North America

12 MAIDEN NAME OF MOTHER: Rosa Hanks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North America

Informant: Miss Esther Thomas

(Address) 3115 Leeds St.

Filed 1 1930 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/27/30

17 I HEREBY CERTIFY, That I attended deceased from 10/21/30, to 11/27/30, that I last saw him alive on 11/26/30, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Hartman M. D.

11/29/30 (Address) 912 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star Cem

DATE OF BURIAL: 12/1/30

20 UNDERTAKER: Charles H. Cooper

ADDRESS: Eutaw St.

Spec.—1-30—M. & T.—250 Bks

E 62825 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62825

CERTIFICATE OF DEATH.

153

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hospitals (St.) 27-56 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Love

(a) RESIDENCE NO. 2917 Woodland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Feb 24, 1887

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
43		9	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Marcella Loves

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosie Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Robt. Love

(Address) 2917 Woodland Ave.

Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-30

17 I HEREBY CERTIFY, That I attended deceased from 11-13, 1930, to 11-29, 1930, that I last saw h[illegible] alive on 11-29, 1930, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of Left Humerus and R Fibia

(duration) yrs. mos 21 da

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 16 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11-25-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Operation

(Signed) Curtis F. Little, M. D.

19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 12/1 1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 E Pratt St

C. HUBERT JONES, M. D.

1 - 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62826

E 62826

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary WARD) #25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Edward Fenton~~ Edward L. Zeigler

(a) RESIDENCE NO. 614 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Married~~ Widower

If married, widowed, or divorced
HUSBAND of
or) WIFE of Amelia Zeigler

DATE OF BIRTH (month, day, and year) April 15th 1867

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	7	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer) Cigars, etc.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Charles Zeigler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Theresa Thunsdorf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Edward Zeigler

(Address) 614 W. Fayette St.

Filed 1-1930 Registrar H. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1930, to Nov 30, 1930,

that I last saw him alive on Nov. 29, 1930,

and that death occurred, on the date stated above, at 3:25 A.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Instantaneous (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) James L. Cummings, M. D.

, 19 (Address) Church Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 12/2/30

20 UNDERTAKER H. Wippert

ADDRESS 330 Eutaw Ave

0—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62827

E 62827

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 9-17 WARD)

2-FULL NAME Emily Fischer

(a) RESIDENCE NO Texas Ave., Parkville ST. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Fischer

6 DATE OF BIRTH (month, day, and year) August 26, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

10 NAME OF FATHER William Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Margaret Stout

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

Informant Henry Fischer

(Address) Parkville, Md.

Filed Nov 26 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia-Abortion about 3 weeks ago.

(History of fall about 4 weeks ago)

down cellar steps (duration) yrs mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Nov 24/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. H. Cain Coroner, M. D.

Nov 26/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 12/1/1930

20 UNDERTAKER F. B. Wyburt — ADDRESS 300 Eutaw Place

Spec.—1-30—M. & T.—250 Bks

E 62828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 101-001

E 62828

REGISTERED NO.

1-PLACE OF DEATH Provident Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division ST. 14 WARD)

2-FULL NAME Joseph Trent

(a) RESIDENCE NO. Simpsonville Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Records

(Address)

FILED 1 - 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29/30

17 I HEREBY CERTIFY, That I attended deceased from 11/27, 1930, to 11/29, 1930, that I last saw h alive on 11/29, 1930, and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Undetermined.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. George McDonald, M. D.

11/30, 1930 (Address) 900 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 12/1 1930

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1631 Druid Hill

Spec.—1-30—M. & T.—250 Bks

62829 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62829

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 15-21 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellwood Richardson

(a) RESIDENCE NO. 1640 Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Richardson

DATE OF BIRTH (month, day, and year) 1849

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Ellwood Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Phyllis ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant (Address) Records of Balto. City Hospitals

Filed 1-1931, H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-28-30

17 I HEREBY CERTIFY, That I attended deceased from 9-6-29, 19..., to 11-28-30, 19..., that I last saw him alive on 11-28-30, 19..., and that death occurred, on the date stated above, at 12:15 A.M.

The CAUSE OF DEATH* was as follows:

Heart disease,
arteriosclerotic
(duration) more than yrs. 14 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No clinical exam

What test confirmed diagnosis?

(Signed) Paul Padget, M. D.

12-1, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 12/1, 1930

20 UNDERTAKER John F. Fahey Sons — ADDRESS 518 Eutaw St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62830

E 62830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) 28-63 (Ward)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Burk

(a) RESIDENCE NO. 4306 Fernhill Rd (St.) _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of Sophia Burk

DATE OF BIRTH (month, day, and year) _____

AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	66			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Optician do

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) R Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address) 4306 Fernhill Rd - B

Filed Dec 1 1930 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 30 - 30

17 I HEREBY CERTIFY, That I attended deceased from 11-26, 1930, to 11-30, 1930, that I last saw him alive on 11-30, 1930, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Lympho-sarcoma

(duration) 3 yrs. _____ mos _____ ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Meltan B Lewis M.D. M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Woods Road	12-1-1930
20 UNDERTAKER Jack Lewis, 1439 E Balto St	ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

E 62831 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62831

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A Kelly Hospital

CITY OF BALTIMORE: (No. 1418 Eutaw place ST. 11-20 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Nancy Marlowe

(a) RESIDENCE NO. Charlestown W. Va. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlestown W Va

PARENTS

10 NAME OF FATHER Geo M. Marlowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlestown W Va

12 MAIDEN NAME OF MOTHER Miss Linton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant: William Marlowe
(Address) Charlestown W Va

15 Filed DEC 3 1930

C. HANCOCK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930, to Dec 1, 1930, that I last saw her alive on Nov 30, 1930 and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal obstruction

1 (duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) appendicocle adhesions (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Charlestown W V.

Did an operation precede death? yes Date of Nov 21/30

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Edmund Kelly, M. D.

, 19 (Address) 141 Eutaw Place Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlestown W Va — DATE OF BURIAL: Dec 3 1930

20 UNDERTAKER: Melvin T. Shuler — ADDRESS: Charlestown W Va.

Spec.—1-30—M. & T.—250 Bks

62832 E 62832

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE. (No.) City Hospital ST. 20-64 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy (Theodore W.) Stansbury

(a) RESIDENCE NO. 2115 Highland Ave ST. WARD
(Usual place of abode) Nativity (If non-resident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widowed

6 If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of Elizabeth Stansbury

DATE OF BIRTH (month, day, and year) Feb. 4, 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	9	25	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 014
(c) Name of employer Consol. Gas & Elec. Co.

BIRTHPLACE (city or town) (State or country) Hampstead, Md.

10 NAME OF FATHER Jeremiah

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hosp Records.
(Address)

Filed ....., 19.. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-18, 1930, to 11-24, 1930, that I last saw him alive on 11-24-?, 1930, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:
Hemorrhage into Cerebrum Rt.
Hypertension.
Unknown (duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) ~~Chronic~~ (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Chas. Chenoweth, M. D.
Nov 24, 1930 (Address) City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Western Cem. DATE OF BURIAL Dec 2 1930

20 UNDERTAKER Geo W Little ADDRESS 2700 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

E 62833

E 62833 HEALTH DEPARTMENT—CITY OF BALTIMORE

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline Ralien ST. 23-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Trochanska

(a) RESIDENCE NO. 1435 Patapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

Single

DATE OF BIRTH (month, day, and year) March 31, 1858

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	72	7	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work American Tobacco Co

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Factory Hand

BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER John Trochanska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miss Emma Littal

(Address) 1435 Patapsco St

Filed ..... 19 .....

C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30-30

17 I HEREBY CERTIFY, That I attended deceased from 11-27, 1930, to 11-30, 1930, that I last saw him alive on 11-30, 1930, and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Uremia (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) N B Hundorf, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk. Cem DATE OF BURIAL Dec 2 1930

20 UNDERTAKER H. Howard Evans ADDRESS 38 E. Fort Ave

ec.—2-29-28—L. F. S.—500 Bks.

E 62834

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62834

CERTIFICATE OF DEATH

159-500

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 E Randall ST. 23-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nancy L. Drake

(a) RESIDENCE NO. 6 E. Randall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Infant

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 24 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Norman F. Drake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katherine M. Callahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

Informant Norman F. Drake

(Address) 6 E. Randall ~~C. HARRISON JONES,~~

Filed 1930, 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1930 - 11.10 P.M.

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1930 to Nov 29, 1930

that I last saw h[illegible] alive on Nov 29 1930

and that death occurred, on the date stated above, at 11:10 P m.

The CAUSE OF DEATH* was as follows:

Bifid Spine

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinically

(Signed) H. H. Campbell M. D.

19 (Address) 16x4 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew

DATE OF BURIAL Dec 1 1930

20 UNDERTAKER H. Howard Evans

ADDRESS 386 E. Fort ave

Dec.—2-29-28—L. F. S.—500 Bks.

E 62835

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62835

CERTIFICATE OF DEATH

129

REGISTERED NO. 16-68

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2424 Arunah Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer E. Cannon

(a) RESIDENCE NO. 2424 Arunah Ave STR. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Cannon

DATE OF BIRTH (month, day, and year): Nov 9 1861

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69		20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Elkridge Md

10 NAME OF FATHER: James W White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah J. Eagleston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

Informant: Ernest L. Solomon

(Address) 2424 Arunah Ave.

FILED Dec 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to Nov. 29, 1930

that I last saw h alive on Nov. 29, 1930

and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Senile Debility Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hellen L Jones M. D.

(Address) 1939 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Dec 3, 1930

20 UNDERTAKER: C. Howard Evans — ADDRESS: 38 E Fort Ave

E 62836 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

62836

90 98879

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH: Bartlett & Hayward Co.

CITY OF BALTIMORE: (No.) Scott & Pratt Sts. ST. 21-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: John J. Murphy.

(a) RESIDENCE NO. 746 W. Hamburg St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If ~~married, widowed, or~~ HUSBAND of ~~WIFE of~~ Minnie Murphy.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Janitor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Bartlett & Hayward Co.
Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Patrick Murphy.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Bridgett ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mary Murphy. (daughter)

(Address) 4304 Springwood Ave.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 28, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Arterio sclerosis.

Coronary sclerosis.

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Bernard, Coroner, M. D.

11/29/30 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: 12/2/1930

UNDERTAKER: Colin Howard & Son

ADDRESS: 701 Hollins St.

1-30—M. & T.—100 B—50L

E 62837 ✓ E 62837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST. 5-8 (WARD)

2-FULL NAME Charles Johnson.(C)

(a) RESIDENCE NO. 600 N.Forrest St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotta Johnson.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Porter.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) South Carolina.

PARENTS

10 NAME OF FATHER Charles Johnson.(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Mary Brown.(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina.

14 Informant Paul Johnson.(C) son.

(Address) 600 N.Forrest St.

15 Filed DEC 1 1930, 19.. E. HARRISON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 30, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st & 2nd degree burns of the body and face. Occidental fall upon a stove during attack of Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 600 N. Forrest St. November 30, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas H. Hamburger, M. D. Coroner

12/1, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Burg-Cremated Dec 3

DATE OF BURIAL 1930

20 UNDERTAKER Edward Hagen

ADDRESS 1631 Orleans

0—M. & T.—100 B—50L

62838

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62838

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 608 Hanover St. ST. 27-30 WARD

2-FULL NAME William H. Watson.

(a) RESIDENCE NO. 608 Hanover St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

If ~~married, widowed, or divorced~~ HUSBAND of ~~wife of~~ Mollie Watson.

DATE OF BIRTH (month, day, and year) Do not know.

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	----	----	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Solicitor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) West Virginia.

10 NAME OF FATHER William Watson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia.

12 MAIDEN NAME OF MOTHER Annie ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia.

Informant William H. Watson. Jr. (son)

(Address) 634 W. Washington St. Hagerstown, Md.

Filed 1930 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 29, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, Coroner, M. D.

12/1 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md. Hagerstown Cpl

DATE OF BURIAL Dec 2 1930

20 UNDERTAKER A. R. Eshleman

ADDRESS Hagerstown Md

Spec.—1-30—M. & T.—250 Bks

Stansbury

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62839

CERTIFICATE OF DEATH.

62839

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hosp ST. 4-30 WARD)

2-FULL NAME Maurice Stansbury

(a) RESIDENCE NO. White marsh ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Laura Stansbury

DATE OF BIRTH (month, day, and year) 1873

AGE	Years	Months	Days	11 LESS than 1 day, hrs. or min.
57				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant Laura Stansbury

(Address) Whitemarsh. Md

Filed 12-1 1930 G. HANSON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-30

17 I HEREBY CERTIFY, That I attended deceased from 11-22, 1930, to 11-27, 1930, that I last saw h[illegible] alive on 11-27, 1930, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Liver abscess, amoebic

Resulting in amoebic

Dysentery

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) Pyelitis, Chronic

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 11-20-30

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) [illegible], M. D.

11/30, 1930 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys. Woodberry.

DATE OF BURIAL 12/2 1930

20 UNDERTAKER John G. Connelly

ADDRESS Essex Md

1-30—M. & T.—100 B—50L

E 62840

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62340

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) On car of No.12 line. ST., 1-3 WARD)

2-FULL NAME Benjamin F. Hoffman.

(a) RESIDENCE NO 2341 Eastern Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ---- mos. ------ ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year) June 4, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER John Hoffman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Rebecca Fickes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Mrs. Earl Cashman. (daughter)

(Address) 2341 Eastern Ave.

15 Filed ..... 1930 ..... 193 ..... [illegible] JOHNS, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) November 30, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas. H. Leonard, M. D. Coroner

12/1, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harrisburg Pa. DATE OF BURIAL: Dec 1 1930

20 UNDERTAKER: Wm C. Black ADDRESS: 927 N. Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62841

CERTIFICATE OF DEATH

101-001

E 62841

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 S. Wolfe Street ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adam Kelwa

(a) RESIDENCE NO. 402 S. Wolfe Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Sept. 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Wladyslaw Kelwa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Kwiatkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Wladyslaw Kelwa

(Address) 402 S. Wolfe St

Filed DEC 1 1930 M. H. JONES, M. D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) nov. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1930, to Nov. 30, 1930, that I last saw h[im] alive on Nov. 29, 1930 and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2/ ds.

CONTRIBUTORY (Secondary) Emphysema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — Date of —

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? P. J. & S.

(Signed) John J. Kruger, M. D.

. 19 (Address) 627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Dec 1 1930

20 UNDERTAKER J. W. Brazewski 1930

ADDRESS

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62842

CERTIFICATE OF DEATH

3/ E 62842

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 236 S. Collington ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Genowefa Potszuski

(a) RESIDENCE NO. 236 S. Collington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1914

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	11		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Adolf Potszuski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Jozefa Podonska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Adolf Potszuski

(Address) 236 S. Collington Ave.

15 Filed DEC 1 - 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1930, to Nov 30, 1930, that I last saw her alive on Nov 28, 1930, and that death occurred, on the date stated above, at 7:00 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P. S & S.

(Signed) John J. Kruger, M. D.

, 19 (Address) 1637 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus DATE OF BURIAL Dec 4 1930

20 UNDERTAKER T. W. Bogucki 1930 ADDRESS Eastern Ave

Spec.—1-30—M. & T.—250 Bks.

E 62843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122 E 62843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. Church Home & Infirmary ST., 13 WARD)

2-FULL NAME Anna Kwasnick

(a) RESIDENCE NO. 408 S. Dunbar ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 1870

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Mrs Cook

(Address) 3018 Hanover Drive

Filed Dec 3, 1930 H. BURTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30/30.

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930 to Nov 30, 1930, that I last saw h[illegible] alive on Nov 29 1930, and that death occurred, on the date stated above, at 4-45 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) ? yrs mos ds

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Howard K. Mengert, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Dec 3 1930

20 UNDERTAKER J. W. Obazewski — ADDRESS 1900 Eastern Ave

0—M. & T.—100 B—50L

E 62844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62844

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Balto City Hos ST. 10-15 WARD)

2-FULL NAME Margaret C. Blowers

(a) RESIDENCE NO 724 Evergreen ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John W Blowers

DATE OF BIRTH (month, day, and year) Mar 8 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	21	

6 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

7 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Cooley

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

Informant James Oreira

(Address) 724 Evergreen

Filed 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and from Hospital records find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Myocarditis & Dilation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James A. Paulson, M. D. Coroner

(Address) 701 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cath. Cem. DATE OF BURIAL Dec 2 1930

20 UNDERTAKER Wm H. Valentine ADDRESS 2326 Aiken St.

C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 62845

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62845

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME Joe Trzeciak

(a) RESIDENCE NO. Kelsyth, W-Va ST., WARD

(Usual place of abode) (If non-resident give city or towo and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced, (write the word)
Male	White	married

6 If married, widowed, or divorced BUSBAND of or) ~~WIFE of~~ Florence

DATE OF BIRTH (month, day, and year) 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Henley Trzeciak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Kore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant JOHNS HOPKINS HOSPITAL

(Address) Records

File 1930 C. HAMPSON JONES, M. D. Registrar

Bur 4068

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 29/30

17 I HEREBY CERTIFY, That I attended deceased from November 13, 1930 to December 29, 1930, that I last saw h. alive on December 29, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Stricture, oesophagus

Perforation of oesophagus

(duration) ....yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? Oswald, West Va.

Did an operation precede death? yes Date of 11-14-30

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) J. H. Alexander, M. D.

Dec. 1, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additioonal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thurmond W Va

DATE OF BURIAL 12/1/30

20 UNDERTAKER Joseph Abrams

ADDRESS 221 Biddy

Spec.—1-30—M. & T.—250 Bks

E 62846 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62846

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 17-24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Butts

(a) RESIDENCE NO. 537 Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Sept 16, 1900

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	2	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Robert Billups

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Carrie Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Hospital Record

(Address)

Filed 1930, 19 Registrar

5230

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24-30

17 I HEREBY CERTIFY, That I attended deceased from 11-16, 1930, to 11-24, 1930, that I last saw her alive on 11-24, 1930, and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Glomerular Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

11/25, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. Also report Contributory Causes.

PLACE OF BURIAL/CREMATION/REMOVAL DATE

19 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M.D.
Commissioner of Health

Saml T. Kennedy 3711 Bdwy

pec.—1-30—M. & T.—250 Bks.

E 62847

E 62847 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X. 45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2107 Carterdale Road ST. 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rowland Hopkins

(a) RESIDENCE NO. Port Deposit Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Robert C. Hopkins

DATE OF BIRTH (month, day, and year) May 10th 1852

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Rowlandsville Cecil Co Md

10 NAME OF FATHER Wm B Rowland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eunice Saffington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mrs David T. Carter

(Address) 2107 Carterdale Road Baltimore Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1930, to Dec. 1st, 1930,

that I last saw her alive on Dec. 1st, 1930,

and that death occurred, on the date stated above, at 11 05 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Coecum

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Port Deposit Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination with anesthetic

(Signed) Wm M. Debey, M. D.

, 19 (Address) Ruxton Md

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Northingham Cem Port Deposit DATE OF BURIAL Dec 3 1930

20 UNDERTAKER Lee A. Patterson ADDRESS Perryville Md

Filed 1930 Per C. HARRISON JONES, M. D. Registrar

0—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62848

E 62848

CERTIFICATE OF DEATH

185

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST. 11-15 WARD)

2-FULL NAME Anna S. Richards.

(a) RESIDENCE NO 8 E. Eager St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs 9 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

DATE OF BIRTH (month, day, and year) January 31, 1860

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	29	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore, Md.

10 NAME OF FATHER: Edward Richards.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Rebecca Read.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

Informant: Viola E. Etheridge. (sister)

(Address) 2025 St. Paul St.

Filed ..... 1930 ..... 192 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): November 29, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra cranial hemorrhage, fracture of middle fossa of the skull.

Accidental fall down stairs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 8 E. Eager St. November 29, 1930

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Reinhardt, M. D. Coroner

12/1, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friends Sem Harford Road — DATE OF BURIAL: Dec 3 1930

20 UNDERTAKER: Geo Schillinglaw — ADDRESS: 1126 Cayonnand

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62849 ✓ E 62849

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4742 Frederick Ave ST. 28-21 WARD)

2-FULL NAME Auguste B. Laudin Beckmann

(a) RESIDENCE NO. 4742 Frederick Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Rudolph Beckmann

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1851.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Zielke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Johanna Laudin

(Address) 4742 Frederick Ave.

15 Filed 1930 . 19 ACH Registrar C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 . 1930 . to Nov 29 . 1930 . that I last saw he alive on Nov 29 . 1930 . and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) Fred T. Kyker, M. D.

, 19 (Address) 3321 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 12/2/30

20 UNDERTAKER Harry A. Weltzke

ADDRESS 410 Edmondson Ave

Spec.—1-10-21—M&T—1500 Blks.

E 62850

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62850

CERTIFICATE OF DEATH.

24-001

1. PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1819 W Baltimore St. (Ward) 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Mrs Jos Hayden

(a) RESIDENCE NO. 1819 W. Baltimore St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Mary Hayden

6 DATE OF BIRTH (month, day, and year): June 10, 1868

7 AGE: Years 62 Months 5 Days 18

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Forrester

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: John Hayden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Leo Hayden 11 N. Arlington Ave

15 1930

19 Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct. 6 1930 to Nov 29 1930.

that I last saw him alive on Nov 28 1930.

and that death occurred, on the date stated above, at 4.35 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. O'Neill M. D.

11/29 1930 (Address) 10 S N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery | DATE OF BURIAL: Dec 2 30

20 UNDERTAKER: Harry N. Witzke | ADDRESS: 4018 Edmondson

Spec.—1-30—M. & T.—250 Bkr.

12/6 N Calvert St. Dr West ✓

E 62851 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62851

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME John Pierpont

(a) RESIDENCE NO. Preston & Valley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/a yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Annie Pierpont

DATE OF BIRTH (month, day, and year) July 4th 1868

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	4	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER John Pierpont

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Noemie Widemeyer

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

Informant Little Sisters of the Poor (Address) Preston & Valley St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30th 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/25 1930 to 11/30 1930, that I last saw h alive on 11/29 1930, and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Contributory (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr Bernard Wise M. D.

12/1 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 12/2 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Fayette

1930 C. HARPER JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62852

CERTIFICATE OF DEATH.

88

E 62852

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2838 W. Garrison Ave ST. 15-61 WARD)

2-FULL NAME Georgeanna Lanphere

(a) RESIDENCE NO. 2838 W. Garrison Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed or divorced (HUSBAND) of (or) WIFE of: Geo. L. Lanphere

6 DATE OF BIRTH (month, day, and year): April 2, 1851

7 AGE: Years 79 Months 7 Days 28 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hartford Co Md

PARENTS

10 NAME OF FATHER: Wm Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hartford Co Md

12 MAIDEN NAME OF MOTHER: Margaret Thatcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hartford Co Md

14 Informant: Mrs. Avalon B. Paulsen

(Address) 2830 Oakley Ave

15 Filed 1 DEC 1930, 19 C. HARRISON JONES, M. D. Registrar

Per WMS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1930, to Nov 30, 1930, that I last saw her alive on Nov 29, 1930, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) yrs. mos. ds. unknown

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D. O'Neill, M. D.

11/30, 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL 12/2 1930

20 UNDERTAKER: Wm Cook

ADDRESS 1217 St Paul

1-30—M. & T.—100 B—50L

E 62853

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62853

CERTIFICATE OF DEATH

185

8-45

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST. ..... WARD .....

2-FULL NAME Lettice M. Coath

(a) RESIDENCE NO 3409 Lake Montebello Drive ST., ... WARD .....

(Usual place of abode) (If ooo-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence J. Coath

6 DATE OF BIRTH (month, day, and year) April 29/1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George M. Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise Donder

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Maryland

14 Informant Clarence J. Coath
(Address) 3409 Lake Montebello Drive

15 Filed ..... 192 ..... C. HARRISON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia - accidently fell from front porch steps on Oct 18/30. and fractured left humerus.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 8/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..... Coroner, M. D.

Dec 1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 12/2 1930

20 UNDERTAKER Thos Cook

ADDRESS 1217 St Paul

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62854

CERTIFICATE OF DEATH

179 E 62854

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hospital 4-46 Ward)

2-FULL NAME Samuel Nickelson

(a) RESIDENCE NO. 933 Homestead St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Nickelson

6 DATE OF BIRTH (month, day, and year) Oct 19 - 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman 062
(b) General nature of industry, business, or establishment in which employed (or employer) State Dept
(c) Name of employer Balto City

9 BIRTHPLACE (city or town) .....
(State or country) Balto Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) "

Informant Ella Nickelson
Address 933 Homestead ave

DEC 1 - 1930

C. HARRISON JONES, M.D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to h death (autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxaemia

Dpd

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 2 & 3 - Diseased Pancreas

Cardiac - Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Harry Tolmusen, M. D.

12/1, 1930 (Address) 7632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	12/3 1930
20 UNDERTAKER W. H. Cook	ADDRESS 147 St. Paul

0—M & T.—100 B—50L

E 62855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62855

181-08

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1017 Ridgely St. (ST.) 21-31 (WARD)

2-FULL NAME Andrew Colopietro.

(a) RESIDENCE NO 1017 Ridgely St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 22 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced, HUSBAND of ~~XXXXXXXXXX~~ Ada F. Colopietro.

DATE OF BIRTH (month, day, and year) September 15, 1889

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	2	15	

6 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

7 BIRTHPLACE (city or town) (State or country) Italy.

10 NAME OF FATHER Salvatore Colopietro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Lotoveka Fuske.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

Informant Ada F. Colopietro. (wife)

(Address) 1017 Ridgely St.

Filed ..... 1930 ..... C. HARRISON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 30, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental illuminating gas poisoning, from a gas heater.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt Coroner, M. D.

12/1, 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL 12/3 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E. Baltimore St.

0—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62856

CERTIFICATE OF DEATH

193 E 62856

REGISTERED NO. 24-32

1-PLACE OF DEATH In a truck on lot of
CITY OF BALTIMORE: (No. 2900 block Annapolis Rd. Westport WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert E. Skipper.

(a) RESIDENCE NO Truck on lot of 2900 block Annapolis Rd. Westport WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

DATE OF BIRTH (month, day, and year) March 2, 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	27	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter. 0-50
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Eli Skipper.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Agnes Constantine.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

Informant Emory E. Skipper. (brother)

(Address) 2219 Sidney Ave. Westport.

FILED 1930 C. HAMPSON JONES M. D., Registrar
Per Cook

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 29, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cold and Exposure.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas. E. Leonard, M. D. Coroner

12/1 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 12/2 1930

20 UNDERTAKER H. M. Cook

ADDRESS 1217 E. Paul St

0—M. & T.—100 B—50L

E 62857

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62857

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) Route to University Hospital CITY, TOWN OR COUNTY ..... WARD .....

2-FULL NAME George A. Hart

(a) RESIDENCE NO 5109 Cordelia Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Willie V. Hart

DATE OF BIRTH (month, day, and year) Nov. 19 1864

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66		11	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watch-man
(b) General nature of industry, business, or establishment in which employed (or employer) 062
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Geo. B. Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER M. Parsons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs. Willie V. Hart

(Address) 5109 Cordelia Ave

1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Gilbert, M. D. Coroner

12/1, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Dec 3 1930

20 UNDERTAKER Wm M Routson

ADDRESS 2238 W North

Cor.—10-10-29—A Co.—100 Bks.

E 62858

HEALTH DEPARTMENT—CITY OF

E 62858

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH St Agnes Hosp S 25-72 (Ward)

City of Baltimore: (No.) Elevator Iglehart

2-FULL NAME E Ellicott Cty Rd

(a) RESIDENCE NO. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Iglehart

6 DATE OF BIRTH (month, day, and year) Apr 29-1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Brauer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Wessel

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Frank Iglehart
(Address) Edmondson Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries which she was a pedestrian struck by truck the hose falling upon her

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening of Arteries

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2 Edmondson Ave Catonsville Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. T. Frame, M. D.

1931, 1930 (Address) 2 Edmondson Ave Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL St. Mary's Cem

DATE OF BURIAL Dec. 2 1930

20 UNDERTAKER Eaton

ADDRESS Ellicott City

Spec—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62859

E 62859

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 S Charles ST. 23-34 WARD)

2-FULL NAME Margaret Klemanski

(a) RESIDENCE NO. 1733 S Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	widow

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) 1/26/1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	10	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John A Batchler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Schrieg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs E. Wise
(Address) Brooklyn Md

Filed 1930 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1929, to Nov 29, 1930

that I last saw her alive on Nov 29, 1930

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Indefinite
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. L. Campbell M. D.

, 19 (Address) 164 S Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	12/2 1930
20 UNDERTAKER J. F. Bakey & Son	ADDRESS 1318 Light

Spec.—1-30—M. & T.—250 Bks

E 62860 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62860

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1623 Bell ST. 7th-3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Rehmke

(a) RESIDENCE NO. 1623 Bell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	widower

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Do. Not Known.

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about 78 or 79 yrs.				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sugar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Do. Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Do Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Mrs. Augusta Rehmke 1623 Bell St.

Filed 1930 Pat C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29. 30

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1930, to Nov 29, 1930, that I last saw h[e] alive on Nov 29, 1930, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Chr Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John F. Ehrenfeld, M. D.

, 19 (Address) 1337 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 12/2/1930

20 UNDERTAKER J. H. Bokey & Son

ADDRESS 1318 Light

Spec.—1-30—M. & T.—250 Bks

E 62861 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62861

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST., 8-17 WARD)

CITY OF BALTIMORE: (NO.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Maude Murray

(a) RESIDENCE NO. None ST., WARD
(Usual place of abode) (If non-resident give city or town and State) Virginia

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Separated

6 If married, widowed, or divorced HUSBAND of or) WIFE of Clifton Murray

DATE OF BIRTH (month, day, and year) 1907

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Edward Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eleanor Sparrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Hospital Records
(Address)

Filed 12-2 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to Nov. 27, 1930, that I last saw her alive on Nov. 27, 1930, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Penner, M. D.

11-27 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middlesex County Va

DATE OF BURIAL Dec 2 1930

20 UNDERTAKER Wm C. Miller 2435 E Oliver

ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 62862 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62862

CERTIFICATE OF DEATH. × 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4-30 WARD)

2-FULL NAME Edward L. Webb.

(a) RESIDENCE NO. Ellicott City Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ellen Webb.

DATE OF BIRTH (month, day, and year) 9/ 1855

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	5	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Henry Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ellen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

Informant Hospital Records

(Address)

Filed ... 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930, to Dec 1, 1930, that I last saw him alive on Dec. 1, 1930, and that death occurred, on the date stated above, at 7:15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial degeneration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical observation

(Signed) George H. Yeager, M. D.

12/1, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ellicott City

DATE OF BURIAL Dec. 4 1930

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62863

CERTIFICATE OF DEATH.

+ 101-001 E 62363

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital 25-72 WARD)

2-FULL NAME Edward John Bruce

(a) RESIDENCE NO. 3601 Connecticut Ave. N.W. ST., Washington D.C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mary C. Bruce

DATE OF BIRTH (month, day, and year) March 28 1897

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33.			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal agent 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Scotland

10 NAME OF FATHER Robert W. Bruce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret McCulloch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

Informant Mrs. Robert W. Bruce

(Address) Washington DC

Filed Dec 2 1930 JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28 1930, to Dec 1 1930,

that I last saw him alive on Dec 1 1930,

and that death occurred, on the date stated above, at 10.50 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. S. Parson M. D.

Dec 1, 1930 (Address) Halethorpe, Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL Dec 2 1930

20 UNDERTAKER John A. Mitchell & Sons

ADDRESS 9 - Eutaw Pl

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 E 62864

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 62864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinia Hospital ST., 27-54 WARD)

2-FULL NAME Abie Richmond

(a) RESIDENCE NO Hebrew Aged Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bella Richmond,

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant San Levin (Nephew)

(Address) 2309 Tioga Parkway

15 Dated 12 1930, 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Arterial sclerosis

Duration yrs. mos ds.

CONTRIBUTORY (Secondary) Fracture of Femur

Duration yrs. mos. ds.

18 Where was disease contracted if not at place of death? Park Royal Ave

Did an operation precede death? no Date of

Was there an autopsy? no clinical

What test confirmed diagnosis?

(Signed) D. Braun, M. D. Coroner

12/1, 1930 (Address) 29 Saint Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Woodlawn Park

DATE OF BURIAL 12-2-1930

20 UNDERTAKER Jacob Lewis, 1139 E Balto St

ADDRESS

1-30—M. & T.—100 B—50L

E 62865

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62865

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. ST. 17-24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. J. Banks

(a) RESIDENCE NO. 1226 Penna Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Banks

6 DATE OF BIRTH (month, day, and year) Mar 15-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Hester Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Susie Banks

(Address) 1226 Penna Ave

15 Filed 12-2 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows

Mitral Stenosis

(duration) yrs. mos. Sudden ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Blum, M. D. Coroner

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 12-2 1930

20 UNDERTAKER Dent Eaton

ADDRESS 916 Park Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62866

CERTIFICATE OF DEATH

113

3-5

E 62866

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. Ward)

2-FULL NAME Rita Albii

(a) RESIDENCE NO. 907 Fawn St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 5/29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Albii

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Concettina Saia

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Louis Albii
(Address) 907 Fawn St

15 Filed 2-1930 [illegible] M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1/30 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acidosis- cause undetermined

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro-intestinal indigestio Probably

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

Dec 2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	12/2 1930
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—9-30—A. & Co.—250 Bks.

E 62867

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62867

CERTIFICATE OF DEATH.

90

1 PLACE OF DEATH

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1924 Cecil Ave ST. 9-18 WARD)

2 FULL NAME Dorothy M. Ward

(a) RESIDENCE NO. 1924 Cecil Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert W. Ward

6 DATE OF BIRTH (month, day, and year) 4-23-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

10 NAME OF FATHER John Tomonen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Feals

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Robt Ward
(Address) 1924 Cecil Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1, 1930

17

I HEREBY CERTIFY, That I attended deceased from Apl 10, 1930, to Nov 30, 1930

that I last saw h[illegible] alive on Nov 30, 1930

and that death occurred, on the date stated above, at Dec, 12:30 m.

The CAUSE OF DEATH* was as follows: 12 30 m

Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. 8 mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

12/1, 1930 (Address) 624 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 12/3/30.

20 UNDERTAKER George J. Tuttle — ADDRESS [illegible]

Cor—12-9-25—A Co—200 Bks.

Dr Mowery

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62868

E 62868

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3008 Barclay St. 12-50 (Ward)

2-FULL NAME Isaac E. Jackson

(a) RESIDENCE NO. 3008 Barclay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Mollie E. Jackson

6 DATE OF BIRTH (month, day, and year): June 10-1864

7 AGE: Years 66 Months 5 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Ind Biscuit

(c) Name of employer: Company

9 BIRTHPLACE (city or town)

(State or country): New Jersey

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): New Jersey

12 MAIDEN NAME OF MOTHER: Fleetwood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant (Address): Mollie E. Jackson 3008 Barclay St.

15 Filed 12 1930 C. ILLIDGE JONES Registrar

Ent

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Edgular Demure 5 hours

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D. (Coroner)

12/1, 1930 (Address) 1432 Poland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — Date of Burial 12/4/11 1930

20 UNDERTAKER: William Cook — ADDRESS 1217 S Caro St.

or.—10-10-29—A Co.—100 Bks.

62869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

199 E 62869

1-PLACE OF DEATH

ity of Baltimore: (No. 3016 Ferndale Ave St.) Howard Park 28-L Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Lee Baven

(a) RESIDENCE NO. 3016 Ferndale Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residenre in rity or town where death occurred 9 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Rare	5 Single, Married, Widowed or Divorred, (write the word)
Female	White	

If married, widowed, or divorred HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 29- 1921

AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	9	2	21	

OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(r) Name of employer

BIRTHPLACE (rity or town) (State or country) City

10 NAME OF FATHER Clarence L Baven

11 BIRTHPLACE OF FATHER (rity or town) City (State or rountry)

12 MAIDEN NAME OF MOTHER Charlotte B. Funk

13 BIRTHPLACE OF MOTHER (city or town) City (State or country)

Informant Clarence L. Baven

(Address) 3016 Ferndale Ave

Filed 12-1930 Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29 1930

17 I HEREBY CERTIFY, That I took charge of the rrmains desrribrd above, held an (Inquest, autopsy or inquiry.) therron and from the evidence obtainrd by said (Inquest, autopsy or inquiry) find that said deceasrd came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by moving auto truck & subsequent

(a) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract skull

(duration) yrs. mos. ds.

18 Where was disease rontracted if not at plare of death? Piedmont & Jamison

Did an operation prerrde death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. L. Fraun, M. D.

12-1 1930 (Address) 2939 W Eldern

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 1 1930

20 UNDERTAKER H. L. Tickner & Co

ADDRESS Walk & Penn

Cor.—12-9-25—A Co.—800 Bks.

E 62870

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62870

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH City of BALTIMORE: (No.) Pronounced Dead at Union Memorial Hospital St. 12-57 Ward

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Frederick Schneider

(a) RESIDENCE NO. 3375 Ash St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J. Schneider

7 DATE OF BIRTH (month, day, and year) December 24, 1857

AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	72	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 3 years

(c) Name of employer Baltimore Copper Wks.

9 BIRTHPLACE (city or town) Harford County

(State or country) Maryland

10 NAME OF FATHER Ferdinand Schneider

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Betzner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

Informant Mr. Wm. F. Schneider (Son)

(Address) 147 S. East Ave.

1930 19 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 29, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Coronary Thrombosis / Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

12/1, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery Date of Burial Dec. 2. 1930

20 UNDERTAKER Henry Sander & Sons, Inc. ADDRESS Baltimore St & Broadway.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 E 62871

62871

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Provident Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division ST. 18th WARD)

2-FULL NAME Charles Smith

(a) RESIDENCE NO. 1067 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years 67 | Months | Days | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hilda Blue Smith

(Address) 602 Orleans

Filed 2 1930 C. HAMILTON JONES, M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30/30

17 I HEREBY CERTIFY, That I attended deceased from 11/28, 1930, to 11/30, 1930, that I last saw him alive on 11/30, 1930, and that death occurred, on the date stated above, at 12 4/6 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Undetermined (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. George McDonald, M. D.

11/30, 1930 (Address) 900 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dahlem

DATE OF BURIAL Dec 3 1930

ADDRESS

19a UNDERTAKER R. A. Parker 3 C Demarahe Dr

Spec.—1-30—M. & T.—250 Blks

E 62872

E 62872 HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

CERTIFICATE OF DEATH.

28-63

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4804 Park Heights Ave ST. WARD

2-FULL NAME Mary Shockney

(a) RESIDENCE NO. 5616 Reisterstown Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 30 1842

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	3	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Carroll Co. Md

10 NAME OF FATHER Stephen Shockney

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Barbara Mummaugh

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

Informant Mrs. Herman A. Johns

(Address) 5616 Reisterstown Road

Filed DEC 2 - 1930

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Dec 1, 1930,

that I last saw her alive on Nov 30, 1930,

and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical & Clinical Symptoms

(Signed) C. D. Turner, M. D.

12-1-1930 19 (Address) 4936 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dove Chapel Cem.

DATE OF BURIAL Dec 3 1930

20 UNDERTAKER Harry W. Eblen

ADDRESS 1944 W. Fayette

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62873

CERTIFICATE OF DEATH

* 75-001 E 62873

1—PLACE OF DEATH Home for Incurables REGISTERED NO. 13-51

CITY OF BALTIMORE: (No. 40th St + Keswick Rd Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Sallie I. Weaver

(a) RESIDENCE NO. Home for Incurables ST., ; WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If ~~married~~ widowed or ~~divorced~~ (or) WIFE of Charles A. Weaver.

DATE OF BIRTH (month, day, and year) July 20 - 1850

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	4	13	

OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Middletown
(State or country) Maryland.

10 NAME OF FATHER David I. Ingram

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

Informant Charles Weaver
(Address) Richmond Va

Filed Dec 5 1930 H. HARRISON JONES, M. D. Registrar

Mar 8 46

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2. 1930

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1930, to Dec. 1st, 1930, that I last saw her alive on Dec. 1st, 1930, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Left Hemiplegia

(duration) — yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) W W Mays M. D.

12/2, 1930 Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Middletown Md	Dec 4 1930
20 UNDERTAKER C. T. R. Gladhill	ADDRESS Middletown Md

-1930

...c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62874

CERTIFICATE OF DEATH

129 E 62874

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No.) 12 N. Milton Ave ST. 6-10 (WARD)

2—FULL NAME Frederick Nicholas Duke

(a) RESIDENCE NO. 12 N Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mrs Bertha Duke

6 DATE OF BIRTH (month, day, and year): Sept 28, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Fire Dept. Capt

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

10 NAME OF FATHER: Frederick Duke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Mrs Bertha Duke

(Address): 12 N. Milton Ave

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1/30

17 I HEREBY CERTIFY, That I attended deceased from July 27, 30, to Dec 1, 30,

that I last saw h[illegible] alive on Nov 30, 30,

and that death occurred, on the date stated above, at 7 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Thom, M. D.

12/1/30, 19 (Address) 6 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem — DATE OF BURIAL: 12/3/1930

20 UNDERTAKER: Louis J Heimann — ADDRESS: 3 S. Broadway

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002

62875 REGISTERED No. F 62875

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1316 Mount ST. 15-22 WARD)

2-FULL NAME Wm Burke

(a) RESIDENCE NO. 1316 Mount ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

If death occurred in a hospital or institution, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 25.1880

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	50	11	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Calvert Co Md

10 NAME OF FATHER David Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Farran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

Informant (Address) Maggie Commodore 1320 N. Mount St.

Filed 12-2-1930 H. Howard Jones, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/28 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/12 .1930. to 11/28 .1930,

that I last saw h[illegible] alive on 11/28 .1930

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

&

Hx. nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) nephritis

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Burkley Tally, M. D.

11/29, 1930 (Address) 2135 Dill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL Dec 2 1930

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Pressbra ST

1-30—M. & T.—100 B—50L

E 62876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 62876

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1349 W. Stricker ST., 5-22 WARD)

2-FULL NAME Thos E. Hall.

(a) RESIDENCE NO. 1349 W. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ss

6 DATE OF BIRTH (month, day, and year) Sept 21-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

10 NAME OF FATHER Saml G Hall.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Eliza Moree

13 BIRTHPLACE OF MOTHER (city or town) (State or country) V. C.

PARENTS

14 Informant Saml G Hall
(Address) 1349 W. Stricker

15 Filed DEC 2 1930 192 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry) Autopsy thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Autopsy find that said deceased came to (Death) Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. Colvin Norris, M. D. Coroner

1930 (Address) Boro

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Dec 2 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pulaski St.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Copy 100-001

E 62877

REGISTERED NO. E 62877

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1329 Whitelock ST. 15-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Owens

(a) RESIDENCE NO. 1329 Whitelock ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) ? 1890 ?

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of Industry, business, or establishment in which employed (or employer) Woodlawn Md Farm Er

(c) Name of employer Mr Anderson

BIRTHPLACE (city or town) (State or country) St Mary's Co

10 NAME OF FATHER William Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Mary Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co

Informant Edward Sykes

(Address) 1633 Eastern Ave

Filed Dec 6, 1930 C. JAMESON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov-30, 1930, to Dec 1, 1930, that I last saw h alive on Novembr 30, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Protozoa Physical

(Signed) Wm A Wright, M. D.

12/1, 1930 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charles Co Md.

DATE OF BURIAL Dec 4 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Prestman St

Spec.—1-30—M. & T.—250 Bks

E 62878

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 62878

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Provident Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division ST. 13 59 WARD)

2-FULL NAME Ella Holland

(a) RESIDENCE NO. 2414 Francis ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed.

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Ella Holland

(Address) 2414 Francis St.

Filed 12-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/28/30

17 I HEREBY CERTIFY, That I attended deceased from 11/26, 1930, to 11/29, 1930, that I last saw h[illegible] alive on 11/29, 1930, and that death occurred, on the date stated above, at 6 30 p.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Cardio-vascular renal disease (duration) [illegible]

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Dr. George McDonald, M. D.

11/30, 1930 (Address) 900 N. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Dec. 2, 1930

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1725 Madison Ave

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62879

CERTIFICATE OF DEATH.

129 E 62879

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 S. Anglesea St. 3-4 WARD)

2-FULL NAME Alexander Zelinsky

(a) RESIDENCE NO. 518 S. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Leokadya Zelinska

DATE OF BIRTH (month, day, and year) Not Known

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	65	0	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Stanislaw Zelinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Leokadya Zelinska

(Address) 518 S. Dallas St

Filed 12-1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1/30

17 I HEREBY CERTIFY, That I attended deceased from 6/1/30, 19..., to 12/1/30, 19..., that I last saw him alive on 11/30/30, 19..., and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) ~~Cause~~ Chronic Interst-itial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R J S Herrmann, M. D.

12/2/30 (Address) 1710 E 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 12/4 1930

UNDERTAKER William Fiaschetti

ADDRESS 69 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62880

REGISTERED NO. 129 E 62880

E 62880

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4023 Edmondson Ave. WARD) 20-71

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry H. McCullough

(a) RESIDENCE NO. 4023 Edmondson ave. ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Mollie L McCullough

DATE OF BIRTH (month, day, and year) Jan 6. 1866

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	10	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City Sewerage Dept.

BIRTHPLACE (city or town) (State or country) Cecil Co. Maryland

10 NAME OF FATHER William McCullough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co. Md

12 MAIDEN NAME OF MOTHER Elizabeth McVey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know.

Informant Mrs. Mollie L McCullough

(Address) 4023 Edmondson Ave.

Filed 2-1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27th 1930, to Dec. 1st 1930

that I last saw h[illegible] alive on Nov. 30th 1930

and that death occurred, on the date stated above, at 1.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no Physical Examination

What test confirmed diagnosis?

(Signed) Paul Brown, M. D.

12/1 1930 Address) 1663 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Dec. 1 1930

20 UNDERTAKER Martin Bakerdine — ADDRESS 822 W. North Ave

Spec.—1-10-21—M&T—1500 Bks.

E 62881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 62881

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2330 Wash Blvd ST., or WARD) 1325 72

2-FULL NAME Florence E Deems.

(a) RESIDENCE NO. 2330 Wash Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo W Deems

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 61 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Edkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Swim

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Geo Deems. (Address) 2330 Wash. Blvd

15 Filed 2 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to December 1, 1930, that I last saw her alive on Dec. 1, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm A Stearns, M. D.

12/1, 1930 (Address) 1901 Griffith.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL: 12/4 1930

20 UNDERTAKER: Edward Foulon ADDRESS: Wash Blvd

Cor.—10-10-29—A Co.—100 Bks.

62882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

REGISTERED NO. E 62882

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 3-1 Ward)

2-FULL NAME Bernard Marzec

(a) RESIDENCE NO. 806 S. Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10/1924

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	6	0	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(r) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Marzec

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Doraczuk

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant St. Joseph Hospital
(Address)

15 Filed Dec 4 1930 Hartley Jones Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death
(Inquest, autopsy or inquiry)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

Acute Nephritis with retent-

CONTRIBUTORY (Secondary)

iOn (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

Dec 1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL Dec 4 1930

20 UNDERTAKER George A. Weber

ADDRESS [illegible]

Spec. 6-9-19 H. P. Co. 1000 Bks.

E 62883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 2830 Elliott St. 1-1 WARD

2-FULL NAME Frank Schultz (Ignacy Antczak)

(a) RESIDENCE NO. 2830 Elliott ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joanna Schultz (Antczak)

6 DATE OF BIRTH (month, day, and year) Jan 15 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem

(c) Name of employer Steel Corp.

9 BIRTHPLACE (city or town) (State or country) Posen Germany.

PARENTS

10 NAME OF FATHER Andrew Schultz (Antczak)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Posen. Germany

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Posen Germany

14 Informant (Address) Joanna Schultz (Antczak) 2830 Elliott St.

15 Filed 12-1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from November 30 1930 to December 1 1930 that I last saw him alive on November 30 1930 and that death occurred, on the date stated above, at 430 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs of death

(Signed) J. B. Bronushas, M. D.

12-1-30 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stanislaus Cem	Dec 5 1930
20 UNDERTAKER Stephen J. Fialkowski Inc	ADDRESS 1000 S. Kenwood Ave

Spec.—1-30—M. & T.—250 Bks

E 62884

E 62884 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Jenkins Memorial Hospital 9-46

CITY OF BALTIMORE: (NO. 1000 Caton avenue ST., WARD)

2-FULL NAME John A Johnson

(a) RESIDENCE NO. 2726 Alameda Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 30 1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 yrs.	1	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Phila. Pa.

10 NAME OF FATHER Thos Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Salina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

Informant (Address) Jenkins Memorial Hosp. 1000 Caton Avenue

Filed 12-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1, 1930.

17 I HEREBY CERTIFY, That I attended deceased from December 20, 1927, to December 1, 1930,

that I last saw him alive on ....., 19.....,

and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

complicating Bronchial Tumor

of Lung

(duration) ....yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Arteriosclerosis

(duration) (?) yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Joseph's Cem. Emmitsburg Md

DATE OF BURIAL Dec 3 1930

20 UNDERTAKER Rita Friedfeld

ADDRESS 914 Fremont Ave

Spec.—9-30—A. & Co.—250 Bks.

E 62885 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 62885

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3421 (ST.) Piedmont Ave (WARD) 15-61

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thos. Bernie

(a) RESIDENCE NO. 3421 Piedmont Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Jane Bernie.

6 DATE OF BIRTH (month, day, and year): June 14 1850

7 AGE: Years 80; Months 5; Days 11; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supt. 80

(b) General nature of industry, business, or establishment in which employed (or employer): Chesapeake Belting Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England.

14 Informant (Address): Mrs Anna Cockey 3421 Piedmont Ave

15 Filed 12-1 1930 Registrar: WAK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 1930, to Nov. 30 1930

that I last saw him alive on Nov 30 1930

and that death occurred, on the date stated above, at 9 25 M.

The CAUSE OF DEATH* was as follows:

A Myocardial insufficiency

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis.

(duration) 6 or 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) W B Barnard Hood M. D.

12/1 1930 (Address) 22 16 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 12-3rd 1930

20 UNDERTAKER: Bernard C Hartz — ADDRESS: 1000 S Paca St.

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62886

CERTIFICATE OF DEATH

90 E 62886

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4801 Laurel Ave ST. 15-56 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Mary Dwyer

(a) RESIDENCE NO. 4801 Laurel Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
(HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 23 1847

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	0	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Fredrich Dreya

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Radika

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miss Anna Kirkman

(Address) 4801 Laurel Ave

Filed DEC 3 1930, 19 WWK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930, to Dec 1, 1930, that I last saw h alive on Nov 30, 1930, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) age -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John T Evans, M. D.

Dec. 1930 (Address) 612 W 40 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Violetville Md.	12-3 1930
20 UNDERTAKER	ADDRESS
Wm Chas G Robb	2337 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 62887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62887

REGISTERED NO. 13

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Asquith Street ST. 10-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sr. M. Jaurentha Mayny

(a) RESIDENCE NO. Convent of Notre Dame ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 5 1893

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	10	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bridgeport

10 NAME OF FATHER Stephen Mayny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Barbara Kuny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

Informant Sr. of Notre Dame

(Address)

Filed DEC 2 1930, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 19 20, to December 1, 19 30, that I last saw h. alive on December 1, 19 30 and that death occurred, on the date stated above, at 5 P m. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cerebral Sclerosis Cord Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) F J Kirby, M. D.

12/2, 19 30 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff, Md.

DATE OF BURIAL Dec. 3 1930

20 UNDERTAKER Frank A. Fink

ADDRESS 915 N. Gay St

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62888 / 16 E 62888

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Carlin Park Woods (St.) 15-62 (Ward) Resterstown and Florida.

2-FULL NAME Wm Keys

(a) RESIDENCE No. Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) about 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 50	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) 045
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

14 Informant N. W Police Record
(Address)

15 Filed ..... 192 ..... Registrar

2 - 52284

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Poison. Carbolic Acid

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Carlin Park

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) ..... M. D.
Coroner

(Address) 1933 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

RECEIVED DEC 2 - 1930

Spec.—1-30—M. & T.—250 Bks

E 62889

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62889

CERTIFICATE OF DEATH.

51

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 26-37 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Collins Reed

(a) RESIDENCE NO. Homeless ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Irene

DATE OF BIRTH (month, day, and year) Aug. 7. 1880

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	3	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Medford N. J.

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Barrie Penisio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

Informant Records of

(Address) Balto. City Hospitals

Filed Dec 2 1930 C. HAMPSON JONES, M. D. Registrar

1930237

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26-30

17 I HEREBY CERTIFY, That I attended deceased from 10-8-30, 19 ..., to 11-26-30 19 ...,

that I last saw him alive on 11-26-30, 19 ...,

and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

more than (duration) yrs. 2½ mos ds.

CONTRIBUTORY (Secondary) Gangrene, diabetic

(duration) yrs. 2½ mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 11-15-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam - lab.

(Signed) Paul Padget. M. D.

12-1, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Spec.—1-30—M. & T.—250 Bks

E 62890 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62890

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 17-24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Percy Whalen

(a) RESIDENCE NO. 922 Shields Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced (or) WIFE of HUSBAND of Unknown

DATE OF BIRTH (month, day, and year) March 4, 1870

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work sells fish, etc.

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Stanton Va.

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky.

12 MAIDEN NAME OF MOTHER Sally Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Records of
(Address) Balto. City Hosp.

Filed DEC 2 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-30

17 I HEREBY CERTIFY, That I attended deceased from 11-6-30, 19 .. to 11-29-30, 19 ..,

that I last saw h im alive on 11-29-30, 19 ..,

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs.

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam. Lab.

(Signed) Paul Padget. M. D.

12-1, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

UNIVERSITY OF MARYLAND

C. Hampson Jones, M.D. Commissioner of Health

DEC 2 1930

2 1930 5938

Spec.—1-30—M. & T.—250 Blks

E 62891 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62891

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1410 Mary ST. 5-8 (WARD)

2-FULL NAME George Washington Johnson

(a) RESIDENCE NO. 1410 Mary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Johnson

DATE OF BIRTH (month, day, and year) July 11 1880

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	4	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

Informant Mrs Johnson

(Address) 1410 Mary St

Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-30

17 I HEREBY CERTIFY, That I attended deceased from 11-28, 1930, to 12-1, 1930, that I last saw him alive on 12-1, 1930, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia a.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

12-3, 1930 (Address) 507 Augusta

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12/3 1930
20 UNDERTAKER	ADDRESS
Curley & Co Inc	1231 N Eutaw

- 1930

H. HARRISON JONES, M.

Spec.—1-30—M. & T.—250 Blks

E 62892 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62892

CERTIFICATE OF DEATH.

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (NO. 1000 Eaton Avenue ST. 25-72 WARD)

2-FULL NAME Bernard Little

(a) RESIDENCE NO. Emmitsburg, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

1659

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71 yrs.			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Emmitsburg

(State or country) Maryland

10 NAME OF FATHER John Little

11 BIRTHPLACE OF FATHER (city or town) Emmitsburg

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia J

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Informant Jenkins Memorial Hospital

(Address) 1000 Eaton Avenue

Filed ..... 1930 ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from November 29, 1930, to December 2, 1930, that I last saw him alive on Dec 1, 1930, and that death occurred, on the date stated above, at 6:00 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical Course

(Signed) Hyman S Anderson, M. D.

....., 19 ..... (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. St. Mary Cem. Emmitsburg Md

DATE OF BURIAL DEC 5 1930

20 UNDERTAKER M. F. Shuff Jr.

ADDRESS Emmitsburg Md

Spec.—1-30—M. & T.—250 Blks

62893 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62893

CERTIFICATE OF DEATH. × 38

1-PLACE OF DEATH Baltimore City Hospitals ST. 16-37 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Henry Davenport

Unknown Stevens Court ST., WARD

(a) RESIDENCE NO. (If non-resident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Birmingham Va.

10 NAME OF FATHER Marion

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elvira ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Records of

(Address) Balto. City Hosp.

Filed 12-1, 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-30

17 I HEREBY CERTIFY, That I attended deceased from 11-26-30, 19..., to 11-29-30, 19..., that I last saw him alive on 11-29-30, 19..., and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency UNKNOWN (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia Movethen (duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam; lab.

(Signed) Paul Padget, M. D.

12-1, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamesville Va

DATE OF BURIAL 12/2 1930

20 UNDERTAKER R. E. Williams

ADDRESS 1515 Madison Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 62894

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62894

CERTIFICATE OF DEATH

101-00

REGISTERED NO.

1—PLACE OF DEATH Balto md

CITY OF BALTIMORE: (No.) 1340 Mount ST. 15-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa Gaither

(a) RESIDENCE NO. 1340 Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1855

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Virginia

10 NAME OF FATHER: Thomas Gaither

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

Informant: Mrs W. H. Lee

(Address) 1323 N Gilmor

Filed DEC 2 1930 C. HAMPSON JONES, M.D. Registrar

Reg'r

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-30

17 I HEREBY CERTIFY, That I attended deceased from NOV 29, 1930, to 12-2, 1930, that I last saw h[illegible] alive on 12-1-30, 1930 and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Baltimore md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R. Boykin, M. D.

, 19 (Address) 1512 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Brown

DATE OF BURIAL: Dec 3rd 1930

20 UNDERTAKER: Thomas E Wright

ADDRESS: 700 N Carrollton Ave

Spec.—1-30—M. & T.—250 Bks

E 62895 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62895

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2907 Belmont Ave. WARD) 16-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Benseler

(a) RESIDENCE NO. 2907 Belmont Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Henry C. Benseler

DATE OF BIRTH (month, day, and year) June 4, 1845

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85.	5	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER Ernest Friedrisien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Friederika Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant (Address) Edith A. Benseler 2907 Belmont Ave.

Filed 1930, 19 ROH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1- 1930, to Dec 1 1930,

that I last saw her alive on Dec. 1 1930,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis followed by acute Hypostatic Pneumonia

(duration) yrs. 4 mos 4 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Pink Sputum & Feble Heart

(Signed) Thos. H. Phillips, M. D.

19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Dec. 3 1930.

20 UNDERTAKER J. M. Rus. ohne & Sons

ADDRESS 801 W. Fayette

Spec.—1-12-23—M&T—500 Blks.

E 62896 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62896

161-09

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Sommerville St. 25-7 Ward)

2-FULL NAME Infant (5 mos) of Berlie Stevens & Bertha Coldsmith

(a) RESIDENCE No. 1912 Sommerville St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Infant (5 mos)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year): Nov 30 1930

8 AGE: Years | Months | Days | If LESS than 1 day, hrs. or 10 min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Balto Md

11 NAME OF FATHER: Berlie Stevens

12 BIRTHPLACE OF FATHER (city or town) (State or country): Md

13 MAIDEN NAME OF MOTHER: Bertha Goldsmith

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

15 Informant

(Address)

1930 Dec 2 (5235) C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1930, to Nov 30, 1930, that I last saw her alive on Nov 30, 1930, and that death occurred, on the date stated above, at 10:10 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? 6 mos, August.

(Signed) Reginald Adams, M. D.

Dec 1, 1930 (Address) 1708 Druid Park Drive

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Potters Field

DATE OF BURIAL: 19

20 UNDERTAKER

ADDRESS

DEC 2 1930

1-30—M. & T.—100 B—50L

E 62897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62897

REGISTERED NO. 74-00

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bull St Hosp ST. 127-48 WARD

2-FULL NAME Catherine Yost

(a) RESIDENCE NO 403 Maryland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Yost

6 DATE OF BIRTH (month, day, and year) Oct 13 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer At Home Balto City

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Chas Calahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Cochran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas Calahan

(Address) 403 Maryland Ave

Filed DEC 2 - 1930 C. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy find that said deceased came to (Inquest, autopsy or inquiry.) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 29/30

Was there an autopsy? Yes Craniotomy

What test confirmed diagnosis? Lewis Hemorrhage

(Signed) James M Hudson, M. D. Coroner

12-2, 1930 (Address) 2002 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Dec 3 1930

20 UNDERTAKER Frank V Spitone

ADDRESS 2818 E Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

E 62898

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62898

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3013 Armnah Ave St., 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Mc Laughlin

(a) Residence No. 3013 Armnah Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 6 1864

7-AGE. 66 yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Unoccupied

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Philadelphia

PARENTS.

10-NAME OF FATHER. James Mc Laughlin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Catherine Duffy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Burlington Vermont

14- (Informant) Joseph Mc Laughlin

(Address) 3013 Armnah

15- Filed ..... 193.. ..... Registrar.

Reg. No. - 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 30, 1930

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1930 to Nov 30, 1930,

that I last saw h[illegible] alive on Nov 30 1930,

and that death occurred, on the date stated above, at 11 53 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical anamnesis

(Signed) L. A. Lakly M. D.

, 19 (Address) 3517 Eldrondale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral - Pikesville 7/4/30

20-UNDERTAKER. George A. Pentz ADDRESS 1705 W. North Ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62899

118-02

E 62899

CERTIFICATE OF DEATH.

REGISTERED NO.

E 62899
1-PLACE OF DEATH

12-19

City of BALTIMORE: (No. West Baltimore General St. Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gerald Eric Tuttle

(a) RESIDENCE NO. 1618 N Calvert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Tuttle

6 DATE OF BIRTH (month, day, and year) December 29, 1900

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	29	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Scranton
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James Tuttle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Katherine Brader

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Mr. Howard Snowden
(Address) Scranton, Pa.

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 2, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
(Coroner)

Dec 2 19 (Address) North Ave. & Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Scranton, Pa. Date of Burial Dec. 5 19 30

20 UNDERTAKER Herbert Cook ADDRESS 1003 West Baltimore St.

pec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62900

CERTIFICATE OF DEATH.

161-001

E 62900

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1929 Perlman Pl 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Taylor

(a) RESIDENCE NO. 1929 Perlman place St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (Write the word): Infant

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year): 12-1-30

AGE	Years	Months	Days	IF LESS than 1 day 5 hrs. or 53 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: God

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town): Balto

(State or country): Md.

10 NAME OF FATHER: Robert Taylor

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine Nolan

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

Informant: Mother

(Address)

Filed

G. HARRISON JONES, M. D.

Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-1-1930

17

I HEREBY CERTIFY, That I attended deceased from 12-1-1930 to 12-1-1930,

that I last saw him alive on 12-1-1930,

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Hovey M. D.

, 19 (Address) 2 X 2 X Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bademan's Cemetery

Date of Burial: Dec 3 1930

20 UNDERTAKER: Henry Lutz

ADDRESS: 1203 N. Broadway

Spec. 1-30—M. & T.—250 Bks.

E 62901 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 62901

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 5412 Catalpha Road (Hamilton) ST. (WARD) 27-44

2-FULL NAME Kunigunda Kohl

(a) RESIDENCE NO. 5412 Catalpha Road (Hamilton) ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

6 If married, widowed, or divorced
(or) WIFE of Late Andrew Kohl

DATE OF BIRTH (month, day, and year) Sept. 25 1849

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	2	7	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Mr. Pellar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

Informant Mrs. Frank G. Kohl
(Address) 5412 Catalpha Road

Filed 3-1930 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1929 to Dec 2 1930,
that I last saw h er alive on Dec 1 1930,
and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Cardio Renal Insufficiency

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) F. E. Kreuter, M. D.
Dec 2 1930 (Address) 1301 N Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 5 1930
20 UNDERTAKER Henry Hoeck Sons, Inc.	ADDRESS 1301 E Eager St

Spec.—1-30—M. & T.—250 Bks

E 62902

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62902

101-007

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 76-1 WARD)

2-FULL NAME Henry Smith

(a) RESIDENCE NO. 704 Clinton St. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of or) WIFE of the late Sarah E. Smith

DATE OF BIRTH (month, day, and year) Oct. 8 nd 1856

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
74	yrs.	1	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Captain do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Nora E. Sheeran daughter

(Address) 407 S. Clinton St.

Filed 1930 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/17/30, 19..., to 12/1/30, 19..., that I last saw h/m alive on 12/1/30, 19..., and that death occurred, on the date stated above, at 1.15 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [redacted] J. Lighs, M. D.

12/1, 1930 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Dec. 4th 1930

20 UNDERTAKER Lilly & Geiler Inc.

ADDRESS 1408 S. Wolfe St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 ✓

CERTIFICATE OF DEATH

E 62903

REGISTERED NO. E 62903

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Brune ST., 11-23 WARD)

2—FULL NAME Jno. E Christy

(a) RESIDENCE NO. 706 Brune ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	widower

If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Rebecca Christy

DATE OF BIRTH (month, day, and year) 1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): md

10 NAME OF FATHER Jos. Christy

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

Informant Annie Satchell

(Address) 608 Brune St

Filed ..... 19.. C. HARRISON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 19 30, to Nov 30 19 30

that I last saw him alive on Nov 29 19 30

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos. ds. —

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) David E. Thaw M. D.

12/1/1930 (Address) 1001 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ash. Auburn Cem — DATE OF BURIAL: Dec 3 1930

20 UNDERTAKER: Samuel Hemsley — ADDRESS: 1700 Eastern

Spec.—1-30—M. & T.—250 Bks.

E 62904

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62904

CERTIFICATE OF DEATH.

123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balti Gen'l Hosp ST., 22-33 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Idella Thompson

(a) RESIDENCE NO. 140 S Marshall St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

6 If married, widowed, or divorced (HUSBAND of or) WIFE of Charles Thompson

DATE OF BIRTH (month, day, and year) Sept 12 1869

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	2	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037 Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Wilmington Del.

10 NAME OF FATHER Abe Banzo.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Esther Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mr. E. H. Thompson
(Address) 140 S Marshall St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-30

17

I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1930, to Dec 2nd, 1930,

that I last saw h[illegible] alive on Dec 2nd, 1930,

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Cholelithiasis - and stone in Common duct

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of Nov. 25. 1930

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm J. Sullivan M. D.

19 (Address) So Balt Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL 12/4 1930

20 UNDERTAKER E. Fenn Mc Cubbin

ADDRESS 1308 Fort

C-1930

Spec.—1-30—M. & T.—250 Bks

E 62905 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62905

CERTIFICATE OF DEATH. 109-002

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 16-37 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Carney

(a) RESIDENCE NO. homeless ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced (or) WIFE of HUSBAND of Minetta

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer out of work

BIRTHPLACE (city or town) (State or country) Crowin N.C.

10 NAME OF FATHER Mike

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Harriett ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

Informant Records of

(Address) Balto. City Hosp.

Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-30

17 I HEREBY CERTIFY, That I attended deceased from 11-29-30, 19.... to 12-1-30, 19....

that I last saw him alive on 12-1-30, 19....

and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Vincent's Angina

(duration) yrs. 24 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. clinical exam.

(Signed) Paul Padget, M. D.

12-2, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart DATE OF BURIAL 12/3 1930

20 UNDERTAKER John J. Fahey Sons ADDRESS 1318 Light St

E. JEFFERSON JONES, M. D. Registrar

Size—12-23-27—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62906

E 62906

16 E 62906

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 306 West Preston St. 11-24 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Boy Willis

(a) Residence No. 306 West Preston St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 23, 1930

7-AGE. yrs. mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, professiou, or particular kiud of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Nannie Gunn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant)

(Address)

15- Filed 192 Registrar.

5245

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11/26/30

17- I HEREBY CERTIFY, That I attended deceased from November 23, 1930 to November 26, 1930 that I last saw h[illegible] alive on November 25, 1930 and that death occurred, on the date stated above, at 9:40A m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Disease of the New Born.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11-28-30 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.

DATE OF BURIAL. 19

20-UNDERTAKER.

ADDRESS

HEALTH OF MARYLAND

Spec.—1-30—M. & T.—250 Bks.

E 62907 HEALTH DEPARTMENT—CITY OF BALTIMORE 73 ✓ E 62907

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 S. East Ave ST. 1-V WARD)

2-FULL NAME Louisa M. Eckhoff

(a) RESIDENCE NO. 238 S. East Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3 If married, widowed, or divorced HUSBAND of or) WIFE of George Eckhoff

DATE OF BIRTH (month, day, and year) 3/12/1844

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	11	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Peter Thiess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Kruse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Anna Hansen

(Address) 238 S East Ave

Filed Dec 3 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 26 1930 to Dec 1 1930

that I last saw her alive on Nov 26 1930

and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows: Progressive Bulbar Paralysis, Ante Mortem. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (Old Age) (Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of —

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) H. C. Hansen M. D.

(Address) 1924 Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Dec 4 1930

20 UNDERTAKER John Ulrich

ADDRESS 200 Aliceanna

1-30—M. & T.—100 B—50L

E 62908

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62908

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Bevan St. ST. 23-31 WARD)

2-FULL NAME Annie Johnson. (C)

(a) RESIDENCE NO 920 Bevan St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs ---------- mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Isaac Johnson. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Henson Heith. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Lethia Smith. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Isaac Johnson. (C) husband.

(Address) 920 Bevan St.

15 Filed ..... 19 ..... C. HARRY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 30, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Alex. Heinhardt, M. D. Coroner

12/1, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Cemetery Dec 4 1930

DATE OF BURIAL

20 UNDERTAKER Ernest Preuger Homeetta

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62909

E 62909

CERTIFICATE OF DEATH.

161-66 13-54

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3027 Kenwick Rd St. C. 13-54 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hatfield

(a) RESIDENCE No. 3029 Kenwick Road St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 hr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or min.
			4 hrs	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Arthur Hatfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Lydia Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge

14 Informant Arthur Hatfield

(Address) 3029 Kenwick Road

15 Filed DEC 3 1930 C. RAMSAY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 2 1930, to Dec 2 1930

that I last saw h alive on 19

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

7 1/2 months Uterine Pregnancy

(duration) 3 hrs yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. E. Richardson M.D.

Dec 3 1930 (Address) 117 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Dec 3 1930

20 UNDERTAKER Chenoweth Son.

ADDRESS 3615 Clifton

Spec. 1-30—M.&T.—250 Bks.

E 62910

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62910

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Cordova Apts. 2 B.

CITY OF BALTIMORE: (No.) Lake Drive & Brookfield Ave. (St.) 13-59 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ray Eichenberg

(a) RESIDENCE NO. Cordova Apts. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Sam Eichenberg

DATE OF BIRTH (month, day, and year) May 8, 1867

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	22 23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 07

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Isaac Blumenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Myer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mr. Sam Eichenberg

(Address) Cordova Apts.

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 31, 19 30 to Dec 1, 19 30,

that I last saw h alive on Dec 1, 19 30,

and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus septicemia (Viridens)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage 6 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz, M. D.

12-2 1930 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem.

DATE OF BURIAL Dec. 3, 1930

20 UNDERTAKER David Sondheim & Son

ADDRESS 1902 Eutaw Place

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62911

CERTIFICATE OF DEATH

90 E 62911

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Madeira ST. 7-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Karhan

(a) RESIDENCE NO. 716 N. Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Karhan

DATE OF BIRTH (month, day, and year) Mar 19 89

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pennsa

10 NAME OF FATHER Frank Karhan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsa

12 MAIDEN NAME OF MOTHER Francis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsa

Informant Mamie Karhan

(Address) 716 N. Madeira St.

Filed G. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 30, to Dec 1, 1930, that I last saw h alive on Nov 30, 1930 and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (Rheumatic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross

(Signed) J. Hampson Jones M. D.

(Address) 700 N. Mitchell St.

12-3-30

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Dec 4 1930

20 UNDERTAKER Frank Veach & Son

ADDRESS 1906 Eastland Ave

Spec. - 1-10-21 - M&T - 1500 Blks.

E 62912

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62912

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 725 Harford Ave ST. 10-14 WARD)

2-FULL NAME James Banks

(a) RESIDENCE NO. 725 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	18	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Banks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Jennie McKlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jennie Banks (Address) 725 Harford Ave.

15 Filed 12-3-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-30 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/16, 1930, to 11/29, 1930, that I last saw him alive on 11/29, 1930, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Ch Pulmonary Th

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) U. H. Hornstein, M. D.

12/3, 1930 (Address) 733 Ausquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL 12-3 1930

20 UNDERTAKER Mrs R. G. Elliott

ADDRESS 1725 Eastlander

Spec.—1-30—M. & T.—250 Blks

E 62913 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62913

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 E. North Ave. ST. 12-20 WARD)

2-FULL NAME Charles J. McLaughlin

(a) RESIDENCE NO. 405 E. North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Adelaide E. Bishop

DATE OF BIRTH (month, day, and year) Feb. 13, 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	9	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Broker

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER James H. McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Lucy E. Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

Informant Mrs. Adelaide E. McLaughlin

(Address) 405 E. North Avenue

Filed DEC 3 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 30 1930 to Dec 2 1930,

that I last saw him alive on Dec 2 1930,

and that death occurred, on the date stated above, at 8-30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm Pearce, M. D.

12-3. 1930 (Address) 1 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/2 1930

20 UNDERTAKER Henry U. Mears

ADDRESS 805 W. Calvert

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62914 — 17 E 62914

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1504 Nolan Alley St., 5-8 Ward)

2-FULL NAME Wm. Poore (Reed)

(a) RESIDENCE NO. 1504 Nolan Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10/65

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	4	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Toney Poore

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Susanna Jones

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Annie M. Winfield
(Address) 2621 Sherman Ave Wash.

15 Filed ..... 19..... C. Raymond Jones M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
3rd degree burns over entire body
Trapped in burning building 1504
Nolan Alley
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos. H. Carter, M. D.

Dec 3/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Dc Rt. Auburn

DATE OF BURIAL 12/3/1930

20 UNDERTAKER
Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

ec.—1-30—M. & T.—250 Blks

E 62915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 62915

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 2 Emlen 30 Jenne ST., 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Simmons

(a) RESIDENCE NO. 279 Jason ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) 1877

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant (Address) Jos. Russell 27 Johnson St

Filed 3-1930 C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1930, to Dec 1, 1930, that I last saw h- alive on Nov 30, 1930, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

Nephritis, chronic

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. C. Hudson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 12-3 1930

20 UNDERTAKER Rennert

ADDRESS 916 Penna

Spec.—1-30—M. & T.—250 Blks

E 62916

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62916

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

17-24

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Coleman

(a) RESIDENCE NO. 1141 Brewer ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Isabelle

DATE OF BIRTH (month, day, and year) 1880 ?

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N. C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of

(Address) Balto. City Hosp.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-30

17 I HEREBY CERTIFY, That I attended deceased from 6-14-30, 19 ..., to 12-1-30, 19 ...,

that I last saw him alive on 12-1-30, 19 ...,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Heart disease,

arteriosclerotic.

(duration) more than yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Town Hospital.

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical sym.

(Signed) Paul Padgett, M. D.

12-, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL 12-3 1930

ADDRESS 916 Eutaw

Spec.—2-28-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

128 ✓

E 62917

REGISTERED NO. E 62917

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2750 Harlem Ave ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lewis William Heinzen

(a) RESIDENCE NO. 2750 Harlem ave ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda C. Heinzen

DATE OF BIRTH (month, day, and year) Mar 28 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68 yr	8	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bulte Wholesale Grocery Co.

BIRTHPLACE (city or town) (State or country) Westfield N. J.

10 NAME OF FATHER Lewis W. Heinzen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

Informant Matilda C. Heinzen

(Address) 2750 Harlem ave

Filed 12-3-1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-1930

17 I HEREBY CERTIFY, That I attended deceased from 11-28- 1930, to 12-2- 1930,

that I last saw h him alive on 12-2-1930, 19—

and that death occurred, on the date stated above, at 3:45 a. m.

The CAUSE OF DEATH* was as follows:

acute glomerular Nephritis

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) none (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What lest confirmed diagnosis? physical signs

(Signed) Chester Riland, M. D.

12-2-1930 (Address) 2532 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible]

DATE OF BURIAL Dec 5 1930

20 UNDERTAKER 7 Vernon Keehn

ADDRESS 1532 Collins

Spec.—8-16-29—L. F. S.—100 Bks.

E 62918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 62918

REGISTERED NO. 25-77

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Cereal St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Gembicki

(a) RESIDENCE NO. 1614 Cereal St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 18-30

AGE: Years | Months 2 | Days 15 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Curtis Bay

10 NAME OF FATHER Stanly Gembicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonina Gardocki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Stanly Gembicki

(Address) 1614 Cereal St

Filed 3-1930 Thaddeus Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1930, to Dec 3, 1930, that I last saw her alive on Dec 3, 1930, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo J. Stoka, M. D.

3, 1931 (Address) 470 Pennington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A&C | DATE OF BURIAL: Dec 4 1930

20 UNDERTAKER: J W Ozazewski | ADDRESS: 1980 Eastern Av

Spec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62919

CERTIFICATE OF DEATH

90 E 62919

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4826 Palmer Ave ST. 27-S WARD)

2—FULL NAME John B Zink

(a) RESIDENCE (NO. 4826 Palmer ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Zink

DATE OF BIRTH (month, day, and year) Nov 11 1848

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82		16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Illinois

10 NAME OF FATHER Phillip Zink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Angela Wolfgang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Eliz Zink

(Address) 4826 Palmer Ave

Filed 1930 G. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Nov 30, 1930, that I last saw him alive on Nov 30, 1930, and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 5 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Edw Talbot, M. D.

12/2, 1930 (Address) 1350 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/4/1930
20 UNDERTAKER	ADDRESS
Forget & Tarby	Fulton & Fayette

Cor.—10-10-29—A Co.—100 Bks.

E 62920

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62920

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. St Agnes Hosp 25-72 Ward)

2-FULL NAME Cecil Dor

(a) RESIDENCE NO. Jonestoro Wash Co. Tenn St.. Ward

(Casual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie King Dor

6 DATE OF BIRTH (month, day, and year) Nov-3-1907

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	23		27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto Mech
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Jonestoro
(State or country) Tenn

PARENTS

10 NAME OF FATHER Chas Dor

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Jonestoro Tenn

12 MAIDEN NAME OF MOTHER Mary Marion

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Rocky Spring Tenn

14 Informant Chas E Dor
(Address) Jonesboro Tenn

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto in which he was the driver ran into a @

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Lumbar Spine with detergement Paralysis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Jamestown Tenn

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Frame M. D.

12/3, 1930 (Address) 29 29th St Elden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamestown Tenn

DATE OF BURIAL 1-3 1930

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollow

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62921 ✓ 90 E 62921

CERTIFICATE OF DEATH

E 62921

REGISTERED NO. 27-55

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 3200 Glen Avenue ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME EMMA LOUISA HORN

(a) RESIDENCE NO. 3200 Glen Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Horn

DATE OF BIRTH (month, day, and year) July 13,1853

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER George Mesner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Moser

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) ~~Germany~~ England

Informant Miss Hazel M. Horn (Daughter)

(Address) 3200 Glen Avenue

Filed DEC 3 1930, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1,1930

17 I HEREBY CERTIFY, That I attended deceased from ~~November~~ March 29, to December 1, 1930,

that I last saw h er alive on November 28, 1930

and that death occurred, on the date stated above, at 10.10a. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History.

(Signed) Palmer F. C. Williams, M. D.

12/1/1930 (Address) Pikesville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Dec. 4, 1930

20 UNDERTAKER Henry Sander & Sons Inc.

ADDRESS Baltimore st. & Broadway.

Cor.—10-10-29—A Co.—100 Bks.

E 62922

HEALTH DEPARTMENT— OF BALTIMORE

105 E 62922

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 6020 Harford Ave St., 27-43 Ward)

2-FULL NAME Harry C. Jones

(a) RESIDENCE NO. 6020 Harford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora L. Jones

6 DATE OF BIRTH (month, day, and year) May 27/1869

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Louis Jones

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Grafton

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mrs Cora L Jones
(Address) 6020 HarfordAve

15 Filed 12-4-1930 By C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

Bronchial Asthma

CONTRIBUTORY (Secondary)

? (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

Dec 1/30 (Address) 508nE. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 12/4/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62923

90 E 62923

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mrs Hosp Retreat St. 17-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora A. Mulcahoney

(a) RESIDENCE No. 401 E Federal St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Mulcahoney.

DATE OF BIRTH (month, day, and year) Dec 24 1876

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer None

BIRTHPLACE (city or town) (State or country) Unknown Ireland

10 NAME OF FATHER Patrick Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Ireland

12 MAIDEN NAME OF MOTHER Bridget Goughan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Ireland

Informant Mrs Hosp Records

(Address) Mrs Hosp Retreat

Filed DEC 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Dec 2, 1930, that I last saw her alive on Dec 1, 1930, and that death occurred, on the date stated above, at 10.9 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Septicaemia)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pre senile Psychosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Bell, M. D.

, 19 (Address) Mrs Hosp Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral Cemetery

DATE OF BURIAL 12/4/1930

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light

Spec.—1-30—M. & T.—250 Bks

Eddie Fisher

E 62924 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 62924

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 monument ST. 5-8 WARD)

2-FULL NAME Estelle Fisher

(a) RESIDENCE NO. 1026 monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Solomon Fisher

DATE OF BIRTH (month, day, and year) 12-2-90

AGE 40	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Newton Ne

10 NAME OF FATHER Solomon Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosa Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Solomon Fisher

(Address) 1026 monument St

Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-30

17 I HEREBY CERTIFY, That I attended deceased from 11-27-30, 19 30, to 12-1, 19 30,

that I last saw h alive on 12-1, 19 30,

and that death occurred, on the date stated above, at 10:15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) ....., M. D.

12-2, 19 30 (Address) 1026 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cem.

DATE OF BURIAL 12-4 1930

20 UNDERTAKER Byron Wright

ADDRESS 1218 McElderry St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62925

62925

CERTIFICATE OF DEATH.

REGISTERED NO. 88

1-PLACE OF DEATH Baltimore City Hospitals ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Thomas Roberts

(a) RESIDENCE NO. 1031 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Earlie

DATE OF BIRTH (month, day, and year) Nov. 9, 1870

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59		23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rudolph Abrams

BIRTHPLACE (city or town) (State or country) Augusta Ga.

10 NAME OF FATHER Frank Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Mollie Hollingshead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

Informant Records of

(Address) Balto. City Hosp.

Filed 12-4-1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-30

17 I HEREBY CERTIFY, That I attended deceased from 7-7-30, 19..., to 12-2-30, 19...,

that I last saw h. alive on 12-2-30, 19...,

and that death occurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Infarct of lung

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home 2 hospt'l.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam; lab.

(Signed) Paul Padget. M. D.

12-3, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Augusta Ga. DATE OF BURIAL 12-5-1930

20 UNDERTAKER Daniel Eaton ADDRESS Ga ne

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62926

CERTIFICATE OF DEATH

D4-001 E 62926

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balt City Hospitals ST. 17-24 WARD)

2-FULL NAME Elizabeth Butler

(a) RESIDENCE No 563 W Hoffman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 48				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Retired on
(c) Name of employer Allcant 7 Fredk

9 BIRTHPLACE (city or town) (State or country) St Mary's Co

PARENTS

10 NAME OF FATHER Joseph Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co

14 Informant Mary Crowford

(Address) 563 W Hoffman

15 Filed 12-2 192 HAROLD JONES, M. D. Registrar

4-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Cystitis and Nephritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James W Rawlins, M. D. Coroner

12-2, 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 12-5 1930

20 UNDERTAKER Dent & Gordon

ADDRESS 916 Or av.

Spec.—1-30—M. & T.—250 Bks.

E 62927 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 62927

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 N. Eastern St. 16-23 WARD)

2-FULL NAME George Dailey

(a) RESIDENCE NO. 1138 N. Eastern ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
M	C	S

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

7 DATE OF BIRTH (month, day, and year) June 16 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER George Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Dailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Mary Dailey
(Address) 1138 N. Eastern

15 Filed ..... 19 ..... C. H. LEON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/3/30

17 I HEREBY CERTIFY, That I attended deceased from 12/1, 1930, to 12/3, 1930, that I last saw him alive on 12/3, 1930, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Lawrence M. D.

19 (Address) 1232 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 12-4-1930

20 UNDERTAKER Wm. H. Chase & Son — ADDRESS 410 N Carey

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62928

CERTIFICATE OF DEATH.

74-6E 62928

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5513 Norwood Ave. (Ward) 28-64

2-FULL NAME Wilhelmina Volke

(a) RESIDENCE No. 5513 Norwood Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late William Volke

6 DATE OF BIRTH (month, day, and year) Sept. 25, 1845.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Catherine Volke,
(Address) 5513 Norwood Ave. Howard Pk.

15 Filed 4-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/1/30, 19 , to 12/2/30, 19 ,

that I last saw h alive on 12/2/30, 19 ,

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) 1 yr mos ds.

CONTRIBUTORY (Secondary) Cerebral Hypoglycemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Bernard J. Fenny, M. D.

12/4/1930 (Address) 960 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 12/4/30

20 UNDERTAKER Harry N. Wintzfeldt, 410 Edmondson Ave. — ADDRESS

Spec.—9-30—A. & Co.—250 Bks.

E 62929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-00 E 62929

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 190 W. Fort Ave (St.) 23rd (WARD) 21

2. FULL NAME Timothy C'Connell

(a) RESIDENCE NO. 190 W. Fort ave ST. 23rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary C'Connell.

6 DATE OF BIRTH (month, day, and year): June 2. 1848

7 AGE: Years 82 | Months 6 | Days | If LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Gd

(b) General nature of industry, business, or establishment in which employed (or employer): Con. Gas and Electric Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John. C'Connell.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mkinnon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary C'Connell. 190 W Fort Ave

15 Filed 1-1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 1929 to Dec 2 1930 (that I last saw him alive on Dec. 2 1930) and that death occurred, on the date stated above, at 7P. M.

The CAUSE OF DEATH* was as follows:

Arteris Sclerosis Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. S. Campbell M. D.

12/3 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Dec 6 1930

20 UNDERTAKER: F. E. Waesche & Son — ADDRESS: 703 Hanover

Spec.—1-30—M. & T.—250 Bks.

E 62930 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62930

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 940 N. Washington ST., 1-13 WARD)

2-FULL NAME Elizabeth Peters

(a) RESIDENCE NO. 940 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed or divorced (or) WIFE of Joseph Peters

DATE OF BIRTH (month, day, and year) Apr. 15 1863

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Henry Timmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Adelsberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Mr. Joseph Peters 940 N. Washington St.

Filed 4-1930 19 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 1930 to Dec 3 1930

that I last saw h alive on Dec 3 1930

and that death occurred, on the date stated above, at 7:55 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Diabetes Mellitus

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Hutchison M.D.

Address 1000 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Dec. 6 19

UNDERTAKER Henry Hoech Sons Inc.

ADDRESS 1001 E. Eager St

Spec.—1-10-21—M&T—1500 Bks.

E 62931 ✓ E 62931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3819 Hayward ave (ST.) 27-55 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie E. Tully

(a) RESIDENCE NO. 3819 Hayward ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Tully.

6 DATE OF BIRTH (month, day, and year)

7 AGE: 59 (Years / Months / Days) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Texas md.

PARENTS

10 NAME OF FATHER: John Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John Tully (Address) 3819 Hayward ave

15 Filed: 1-4-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-3 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-28, 1930, to 12-3, 1930, that I last saw her alive on 12-2-, 1930, and that death occurred, on the date stated above, at 7.50A m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Myocarditis
Arteriosclerosis &
Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Embolus

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eliot W. Johnson, M. D.

1/3, 1930 (Address) 3326 Eutaw ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Texas md.

DATE OF BURIAL: Jan. 6, 1930

20 UNDERTAKER: Conley & Co. Inc. 104 N. Eutaw ave

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62932

E 62932

90

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 761 Mullikin St St., 2-4 Ward)

2-FULL NAME Joseph Dorsey

(a) RESIDENCE NO. 310 N. Ann St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willie Dorsey

6 DATE OF BIRTH (month, day, and year) Dec 17/1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	34	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER John H. Dorsey

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Chapman

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Mamie Ford
(Address) 1837 Orleans St

15 Filed 4-1930 19.... Registrar
C. HARRISON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency-Probably Valvular
(World War Veteran-Reed Hosp)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. H. Dorsey, M. D.

Dec 4/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Lawn	12/7/30
20 UNDERTAKER E Bryan	ADDRESS 1631 Orleans

Spec.—1-30—M. & T.—250 Bks.

✓ E 62933

242836

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62933

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 6-9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Williams

(a) RESIDENCE No. 1508 Mulliken ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of or) WIFE of ?

7 DATE OF BIRTH (month, day, and year) Oct-17-1894

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	1	14	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Sam Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Julia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930 to Dec 1, 1930

that I last saw h.r alive on Dec 1, 1930

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Laboratory

Did an operation precede death? Date of

Was there an autopsy? Yes Blind process 2 eyes.

What test confirmed diagnosis? Autopsy Examination Microscopic

(Signed) Franklin F. Snyder M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stevens cemetery

DATE OF BURIAL: Dec 4 1930

20 UNDERTAKER: Edward Bryan

ADDRESS: 631 Orleans St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62934 ✓ 129 E 62934

CERTIFICATE OF DEATH

E 62934

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 727 Eastern Ave ST. (10-14 WARD)

2—FULL NAME ~~Silas Wilson Harrison~~ James Wilson Harrison

(a) RESIDENCE NO. 729 Ensor St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1875

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sawyer 076

(b) General nature of industry, business, or establishment in which employed (or employer) Box Mfg.

(c) Name of employer Becker Bros

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER James Wilson Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Mrs. C. W. Bonnell

(Address) 1151 N. Capitol St. Washington, D. C.

Filed 1930 HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Dec 2, 1930, that I last saw h[illegible] alive on Dec 2, 1930 and that death occurred, on the date stated above, at 8 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

5 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hernia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Reich M. D.

12/3, 1930 (Address) 4366 Hammond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL 12/4 1930

20 UNDERTAKER C. Vernon Lemmon. ADDRESS 4611 Park Heights Ave.

Spec.—1-30—M. & T.—250 Bks

E 62935 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62935

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415. S. Collington Ave. | 3 WARD)

2-FULL NAME Andrew Kwiatkowski

(a) RESIDENCE NO. 415 S. S. Collington Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of ~~or WIFE~~ of Catharine Kwiatkowski

6 DATE OF BIRTH (month, day, and year) Oct. 25-1887

7 AGE: Years 43 | Months 1 | Days 7 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER Feliy Kwiatkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER St. Stachowiak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Catharine Kwiatkowski 415 S. Collington Ave

15 Filed ... 19 ... Registrar

1930 REGISTERED NO.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to Dec. 7, 1930,

that I last saw h~~im~~ alive on Dec. 7, 1930

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis with Hypertension — Angina Pectoris —

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Cardio-Vascular decompensation

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas J. Feingold M. D.

12/3, 1930 (Address) 700 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL 12/6 1930

20 UNDERTAKER: William Fiaschetti — ADDRESS 118 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62936

CERTIFICATE OF DEATH

X 100-001 ✓

E 62936

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1417 N Bruce ST. (WARD) 15-21

2—FULL NAME Daisy Little Hoop

(a) RESIDENCE NO. 1417 Bruce ST., WARD 9a

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married,

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Calvin Hoop.

7 DATE OF BIRTH (month, day, and year) 1884

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Walter Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Goldie Richardson

(Address) 1417 N Bruce st

Filed ..... 19 ..... Registrar

DEC 4 -

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1-30

17 I HEREBY CERTIFY, That I attended deceased from 11-28, 19 30, to Dec 1, 19 30

that I last saw h alive on Nov 30, 19 30

and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Hatcher M. D.

12-4, 19 30 (Address) 4220 Par Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Dec 4 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

1-30—M. & T.—100 B—50L

62937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62937

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Grindall Court. ST. 22-6 WARD)

2-FULL NAME Annie Jones.(C)

(a) RESIDENCE NO 729 Grindall Court. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow.

5a If ~~married, widowed, or divorced~~ (or) WIFE of Matthew Jones.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	About 60	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Rose Jones.(C) daughter)
(Address) 729 Grindall Court.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto A. Einhardt, M. D. Coroner

12/2, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon

DATE OF BURIAL 12/4/30.

20 UNDERTAKER R. L. Parham

ADDRESS Arnoldia Md

[illegible] 1930 [illegible] REGISTERED

Spec.—1-30—M. & T.—250 Bks.

E 62938 HEALTH DEPARTMENT—CITY OF BALTIMORE 146 E 62938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST., 2534 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Martha Regan

(a) RESIDENCE No. 1714 Patapsco ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Thomas J Regan

7 DATE OF BIRTH (month, day, and year): April 1897

8 AGE — Years: 33 — Months: 7 — Days: — If LESS than 1 day, hrs. or min.:

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Balto Md

11 NAME OF FATHER: August Stucken

12 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

13 MAIDEN NAME OF MOTHER: Don't know

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't know

15 Informant: Thomas J Regan
(Address): 1714 Patapsco St

Filed Dec 3 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1930, to Dec. 2, 1930,
that I last saw h[illegible] alive on Dec 2, 1930,
and that death occurred, on the date stated above, at 11:10 P. m.

The CAUSE OF DEATH* was as follows:
Acute Endometritis
Septicemia (Staphylococcus)
(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1714 Patapsco St
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Blood culture, autopsy
(Signed) M. B. Kirsch, M. D.
, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Dec 7 1930

20 UNDERTAKER: A. Leland Evans — ADDRESS: 2[illegible] Gay St

Spec.—9-30—A. & Co.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62939 — 129 — E 62939

1 PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) 1776 Marshall St. 24-34 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Anna R Wolf

(a) RESIDENCE NO. 1776 Marshall ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Daniel M. Wolf

6 DATE OF BIRTH (month, day, and year): June 13, 1863

7 AGE — Years: 67 — Months: 5 — Days: 31 — If Less than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Frederick Co. Md

PARENTS
10 NAME OF FATHER: Benjamin Strine
11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co Md
12 MAIDEN NAME OF MOTHER: Margaret Kuhntz
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co Md

14 Informant (Address): Mrs G Walther 517 Cedar Ave

15 FILED: 4-1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12, 4, 30 - 10.45 P.M.

17
I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Dec 1, 1930
that I last saw h er alive on Dec 1, 1930
and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease

(duration) unknown yrs. mos. ds.
CONTRIBUTORY (Secondary): Chronic diffuse nephritis
(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phys + Lab
Signed) Mule Stifler M. D.
Dec 5 1930 (Address) 1319 Light St.

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Eastern Cem — DATE OF BURIAL: Dec 5 1930

20 UNDERTAKER: A. Kraus / Evans — ADDRESS: 35 E Fort Ave

Spec.—1-30—M. & T.—250 Bks

E 62940 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62940

CERTIFICATE OF DEATH. 74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4714 Belair Road ST. 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Reddall

(a) RESIDENCE NO. 4714 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Oct. 14 1848

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
82	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER William Wesley

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Jones

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mrs. Jane Graf

(Address) 4714 Belair Road

15 Filed DEC 3 1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1930, to Dec 2, 1930, that I last saw her alive on Dec 2, 1930, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) [illegible], M. D.

12/3 1930 (Address) Maple Ave & Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec. 5 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Cager St

I-30—M. & T.—100 B—50L

E 62941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-801 E 62941

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2501 N Calvert ST. 12-50 (WARD)

2-FULL NAME Earl R. Sadtler.

(a) RESIDENCE No 2501 N Calvert ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 4th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min
	46	0	29.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of Industry, business, or establishment in which employed (or employer)
Clerk.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. J. Sadtler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Maud Barlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant Henry A. Sheppard

(Address) 2519 N Calvert st.

15 Filed DEC 4 - 1930 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Gas Poisoning Ill.

(duration) 1 yrs. mos — ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy Ex

(Signed) Geo Edmondson Cadell, M. D. Coroner

, 19 (Address) 143 W 13 way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount.

DATE OF BURIAL 12/5 1930

20 UNDERTAKER Chas G. Black

ADDRESS 7427 N. North.

30—M. & T.—100 B—50L

E 62942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62942

REGISTERED NO. 24133

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Ahern.

(a) RESIDENCE NO 71 Lake St. Lewiston, Me. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of Lillian Ahern.

DATE OF BIRTH (month, day, and year) Do not know.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	----------		

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocery clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lewiston, Me.

10 NAME OF FATHER Charles Ahern.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lewiston, Me.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know,

Informant William Connors.

(Address) 161 Bartlett St. Lewiston, Me.

Filed 4-1930 PARKSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 2, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries.
Kicked in the abdomen by a horse.
Occidental Death.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bowie Race track. November 25, 1930

Did an operation precede death? Yes. Date of Nov. 25, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Einhard, M. D. Coroner

12/8, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lewiston Maine

DATE OF BURIAL Dec. 4, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Baltimore

Spec.—9-30—A. & Co.—250 Bks.

E 62943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-00

REGISTERED NO. E 62943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 Woodlawn Road ST. 27-53 WARD.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances D. Swett

(a) RESIDENCE No. 222 Woodlawn Road ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in City or Town where death occurred 4 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 24, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Woodward W. Swett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Lydia Owen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Mrs. Elizabeth M. Burrough
(Address) 222 Woodlawn Road

15 Filed 12/4/1930 HARRY C. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/3/30

17

I HEREBY CERTIFY. That I attended deceased from 10/28, 1930, to 12/2, 1930.

that I last saw her alive on 12/2, 1930

and that death occurred, on the date stated above, at 2:10 P m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral vascular changes with convulsions

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. H. Schaab M. D.

12/4 1930 (Address) 1403 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston, Massachusetts

DATE OF BURIAL Dec. 4, 1930

20 UNDERTAKER John C. Mitchell & Sons, 1900 Eutaw Pl.

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 62944

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62944

CERTIFICATE OF DEATH

46

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 Fulton Ave ST. 50-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Heyer

(a) RESIDENCE NO. 440 Fulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

If married, widowed, or divorced BUSBAND of (or) WIFE of Otto Heyer

DATE OF BIRTH (month, day, and year) Aug 2-1871

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	4	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Ernest Heyer Jr

(Address) 440 Fulton St

Filed 12-4-1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1- 1930 to Dec 2 1930

that I last saw h. alive on Dec 2 1930

and that death occurred, on the date stated above, at 9 0 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Senile Dementia

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Valvular Disease (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert C Hunter M. D.

12/3/1930 (Address) 2151 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem.

DATE OF BURIAL Dec 5 1930

20 UNDERTAKER Chas W. Dill.

ADDRESS 3109 Fredk Ave.

Spec.—1-30—M. & T.—250 Bks.

E 62945

E 62945

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 7-13 WARD)

2-FULL NAME Frances Hinton Catonsville Md

(a) RESIDENCE NO. 804 Augusta Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 23. 1926

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
4	6 7	11 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Wilbur R Hinton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Verna R Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wilbur R Hinton

(Address) 804 Augusta Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3. 1930

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1930 to December 3, 1930, that I last saw h 2 alive on December 3, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

acute Lymphatic Leukemia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) Milton B Cross, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove, Balto Co Md

DATE OF BURIAL 12/6 1930

20 UNDERTAKER W M Cook

ADDRESS 1217 E Fayette St

Spec.—0-30—A. & Co.—250 Bks.

Dr Mayer 2438 Eutaw Place

Laf 1853

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62946

CERTIFICATE OF DEATH.

4th V E 62946

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 986 Franklintown Rd St. 28-66 WARD)

2. FULL NAME John F. Childs

(a) RESIDENCE NO. 986 Franklintown Rd WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How Long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 20 1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	9	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph S Childs
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Sally Ward
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter Childs
(Address) 986 Franklintown Rd

15 Filed 4-6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 2nd 1930

17
I HEREBY CERTIFY, That I attended deceased from November 2, 1930, to December 2, 1930
that I last saw him alive on December 1, 1930
and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of the Liver

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis?

(Signed) H. A. H. A. Mayer M. D.
Dec. 2, 1930 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 12/5/1930

20 UNDERTAKER Wm Cook 1217 E Pratt St — ADDRESS

1-30—M. & T.—100 B—50L

E 62947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1930 E 62947

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Good Shepard 2416 ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Wieder

(a) RESIDENCE NO. 1714 Harlem ST., ... WARD .....

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Jos Wieder

11 BIRTHPLACE OF FATHER (city or town) Frederick Md (State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Lady of Lourdes Hospital

(Address) 329 W Hollins

15 Filed Dec 5 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 3rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Abortion (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? In Frederick Co.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular Autopsy

(Signed) Harold Hutchins Coroner, M. D.

(Address) 3 E Church Frederick Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Joseph Cemetery Buckeystown Md

DATE OF BURIAL Dec 6 1930.

20 UNDERTAKER W. R. Etchison & Co

ADDRESS Frederick Md

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62948

167-001
167-E 62948

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2308 Annapolis Rd St. 25-32 Ward)

2-FULL NAME Anna S. Cossaboom

(a) RESIDENCE NO. 2308 Annapolis Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of S. M. Cossaboom

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N. J.
(State or country)

PARENTS

10 NAME OF FATHER Jas. Steelman

11 BIRTHPLACE OF FATHER (city or town) N. J.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Curran

13 BIRTHPLACE OF MOTHER (city or town) N. J.
(State or country)

14 Informant S. M. Cossaboom
(Address) 2308 Annapolis Rd

15 Filed ..... 19 ..... Registrar

1930 U. S. CENSUS NOS. 1-4

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide. by illuminating gas. at home

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. J. Brooks, M. D.

Dec. 2 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Dec 5 1930

20 UNDERTAKER William G. Schaffer — ADDRESS 1816 Monument

Cor.—10-10-29—A C.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

148 E 62949

CERTIFICATE OF DEATH

E 62949

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 8-13 Ward)

2-FULL NAME Anna Stewart

(a) RESIDENCE NO. 1706 E. Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Stewart

6 DATE OF BIRTH (month, day, and year) June 17/1896

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34	5	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER John Stokes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Edward Stewart
(Address) 1706 E. Chase St

15 Filed Dec 4 1930 Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis-Endocarditis

Abcesses of lung- septic emboli

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Still birth 5 hrs before death.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at St. Joseph

What test confirmed diagnosis?

(Signed) [signature] M. D.

Dec 4/30 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Dec 5 1930
20 UNDERTAKER	ADDRESS
Frank Brach & Son	906 Oakland

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 62950

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62950

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (No. 5-8 ST. WARD)

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Burke

(a) RESIDENCE NO. 100 N. Front ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	83?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 69

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edward Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jeannette Charles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Records of Balto. City Hosp.

15 Filed Dec 4 - 1930 W. H. STUART NOSS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-30

17 I HEREBY CERTIFY, That I attended deceased from 6-3-30, 19..., to 12-2-30, 19..., that I last saw him alive on 12-2-30, 19..., and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Heart disease, arteriosclerotic

(duration) more than yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? In our 2. hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Puget, M. D.

12-4, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's Cemetery	Dec 4 1930
20 UNDERTAKER H. Sander Sons Inc	ADDRESS 1710 Eutaw

Spec.—1-30—M. & T.—250 Bks

E 62951

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62951

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 E. Fort Ave ST. 24-33 WARD)

2-FULL NAME Mary Cinquegrani

(a) RESIDENCE NO. 706 E. Fort Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27, 1929

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ditto

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Vincent Cinquegrana

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Emanuella Del Aqua

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Cinquegrani
(Address) 706 E. Fort Ave

15 Filed 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3rd, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1930, to Dec. 3, 1930, that I last saw her alive on Dec. 3, 1930, and that death occurred, on the date stated above, at 5.30 Am.

The CAUSE OF DEATH* was as follows:

Left Lobar Pneumonia
Right Bronchopneumonia
(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema-Cardiac Dilatation (duration) ..... yrs. ..... mos. 1 da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dr. A. Bonanno, M. D.

, 19 (Address) 436 E. Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Dec 5th 1930

20 UNDERTAKER Frank V. Pepitone

ADDRESS 2818 E. Baltimore St

Spec.—1-30—M. & T.—250 Bks.

E 62952

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 62952

CERTIFICATE OF DEATH

1-PLACE OF DEATH Balto. City Hospitals

CITY OF BALTIMORE: (No. Balto. Md. St. 15-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edgar Fisher

(a) RESIDENCE NO. 701 Ashburton St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Margaret Fisher

6 DATE OF BIRTH (month, day, and year): 6-17-1880

7 AGE: Years 50 Months 5 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Cyrus Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Sarah McCann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Relative Balto City Hosp

15 Filed Dec 5 1930 ARTHUR JOHNS, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/3/30

17 I HEREBY CERTIFY, That I attended deceased from 11/20/30, 19 to 12/3/30, 19, that I last saw him alive on 12/2/30, 19, and that death occurred, on the date stated above, at 6:47 a.m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Toxic Y Ethanolosis

Paralysis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Harry H. Adams M. D.

12/3 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: Dec. 5 1930

20 UNDERTAKER: Ebenezer Lon Chestnut Sr

ADDRESS 3617

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62953

E 62953

CERTIFICATE OF DEATH

REGISTERED NO. 90 28-64

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) 5516 Wayne Av ST., 28 WARD)

2—FULL NAME William E. Kastendike

(a) RESIDENCE NO. 5516 Wayne Av ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or WIFE of): Fran. Kastendike

6 DATE OF BIRTH (month, day, and year): Mar 26-1861

7 AGE: Years 69 | Months 8 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Advisory Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Albany N.Y.

10 NAME OF FATHER: John W. Kastendike

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.

12 MAIDEN NAME OF MOTHER: Meehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. City

14 Informant: Mrs. Kastendike

(Address) 5516 Wayne Av

Filed Dec 4 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2 30

17 I HEREBY CERTIFY, That I attended deceased from Nov 25 1930, to Dec 2 1930, that I last saw h alive on Dec 2 1930 and that death occurred, on the date stated above, at 5-P m.

The CAUSE OF DEATH* was as follows:

Bronchitis + Hypostatic congestion of Lungs (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Myocarditis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) A. C. Lamb, M. D.

Dec 3, 1930 Address 4309 Liberty Hts Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery DATE OF BURIAL Dec 5 1930

20 UNDERTAKER: A. S. Marshall ADDRESS 353 Fallsway

Spec.—1-30—M. & T.—250 Bks.

E 62954 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62954

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 602 N. Spring ST. 5-9 (WARD)

2-FULL NAME John W. Harris

(a) RESIDENCE NO. 602 N. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Addie Harris

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Harris

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Bias

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Addie Harris Wife

(Address) 602 N. Spring St.

15 Filed Dec 1930 C. HARRISON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Dec 1, 1930,

that I last saw h alive on Nov 30, 1930,

and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy & Effusion

6 wks

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lindsay, M. D.

Dec 2, 1930 (Address) 1424 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary DATE OF BURIAL Dec 5 1930

20 UNDERTAKER Mrs R. G. Elliott ADDRESS 1925 Ashland Ave

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62955

CERTIFICATE OF DEATH

E 62955

REGISTERED NO. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 27-47 Ward)

2-FULL NAME John H. Jones

(a) RESIDENCE NO. 202 Hillen Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Jones

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Young

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Ella Jones (wife)
(Address) 202 Hillen Road

15 DEC 4 - 1930 G. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (Hemorrhage)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Woodlea & Russell

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. S. Kalm M. D.

Dec 4/30 (Address) 208 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Baltimore Md.

DATE OF BURIAL Dec 5 1930

20 UNDERTAKER R. A. Elliott

ADDRESS 1725 Pulaski

Important.—See instructions on back of certificate.

Spec.—9-30—A. & Co.—250 Bks.

62956 HEALTH DEPARTMENT—CITY OF BALTIMORE 62956

CERTIFICATE OF DEATH

REGISTERED NO. 1291

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3010 Park Side Drive ST. 8-44 WARD 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary E. Gebald

(a) RESIDENCE NO. 3010 Park Side Drive ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How Long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md.

10 NAME OF FATHER Samuel Lyle E. Gebald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County Md.

12 MAIDEN NAME OF MOTHER Virginia L. Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County Md.

14 Informant Mrs. Mark R. Gebald (Address) 3010 Parkside Drive

15 Filed [illegible] 16 Registered [illegible]

4-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2-1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 4th, 1930, to Dec 2nd, 1930

that I last saw her alive on Dec 1st, 1930

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Usual

(Signed) H. D. Krammes M. D.

Dec 2 1930 (Address) 724 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Walkersville Md.

DATE OF BURIAL 12/5/1930

20 UNDERTAKER C. B. Wetzel Inc. 850 N. Bell St

ADDRESS

C. RALPHSON JONES, M. D.

Spec.—9-30—A. & Co.—250 Bks.

62957 HEALTH DEPARTMENT—CITY OF BALTIMORE

62957

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 E. Lafayette St. 8-17 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Catherine Sharp

(a) RESIDENCE NO. 1208 E. Lafayette ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Sharp

6 DATE OF BIRTH (month, day, and year) Apr 27 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Engel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carrie Satterfield
(Address) 1208 E. Lafayette

15 DEC 5 - 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1930, to Dec 4th, 1930, that I last saw h[illegible] alive on Nov 26th, 1930, and that death occurred, on the date stated above, at 11½ a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Steinberg M. D.

, 19 (Address) 3735 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Dec 6, 1930

20 UNDERTAKER Wm. Cook Co. ADDRESS 1217 Ashland

Spec.—1-30—M. & T.—250 Bks.

E 62958 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62958

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Wilkens & Eatons Lanes ST. 10-12 WARD)

2-FULL NAME Herman Brauer

(a) RESIDENCE NO. 545 Kelly St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Katherine Brauer

6 DATE OF BIRTH (month, day, and year) Nov 29, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Grimm Bakery

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry Brauer

(Address) 545 Kelly St

15 DATE RECEIVED 1930 Registrar C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1930, to Dec. 4, 1930, that I last saw h ~~ive~~ on Dec. 4, 1930, and that death occurred, on the date stated above, at 7.4 a.m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory.

(Signed) Hy almer S Anderson M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 12/5 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62959

CERTIFICATE OF DEATH

X. 14 / E 62959

REGISTERED NO. 11234

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary S. Crandell.

(a) RESIDENCE NO. English Consul, Balto. Co., Md. Magnolia Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert A. Crandall

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Calvert Co, Md.

10 NAME OF FATHER Stephen Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Ward.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hospital Record.

(Address)

I certify that I attended deceased from Nov. 17, 1930 to Dec. 3, 1930

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1930, to Dec. 3, 1930,

that I last saw her alive on Dec. 3, 1930

and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Procidentia Uteri

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-20-30

Was there an autopsy? No

What test confirmed diagnosis? Vincent

(Signed) Robert A. Crandell, M. D.

. 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem

DATE OF BURIAL Dec 6, 1930

20 UNDERTAKER Mrs. Jno. W. Tenfelt & Son

ADDRESS 801 W. Fayette St.

Spec.—1-30—M. & T.—250 Bks

E 62960 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62960

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 16-26 ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Decker

(a) RESIDENCE NO. 773 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Decker

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1868

7 AGE	Years	Months	Days 5	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Allentown N.J.

PARENTS

10 NAME OF FATHER Samuel Stratton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.J.

12 MAIDEN NAME OF MOTHER Mary Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 1930, 19 HAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-30

17 I HEREBY CERTIFY, That I attended deceased from 8-1-30, 19..., to 12-1-30, 19..., that I last saw her alive on 12-1-30, 19..., and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease,
arteriosclerotic.
Myocarditis (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - senile. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

12-3, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fallen Mount Cem. | DATE OF BURIAL Dec. 5 1930

20 UNDERTAKER John C. Miller & Co | ADDRESS 35 E Lexington

Spec.—9-30—A. & Co.—250 Bks.

E 6296 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 62961

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No 1413 - Ensor St St 9-14 WARD)

2. FULL NAME Anna M. Adler

(a) RESIDENCE NO. 1413 - Ensor St ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos ds. How Long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Adler

6 DATE OF BIRTH (month, day, and year) 4-6-1845

7 AGE Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
85	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Seikel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mrs. A. Adler
(Address) 1413 Ensor St

15 Filed ..... 19.... C. HARRISON JONES, M. D. Registrar

4-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1930

17

I HEREBY CERTIFY, That I attended deceased from Nov 26th, 1930, to Nov 27th, 1930

that I last saw her alive on Nov 27th, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach ?
(duration) ... yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. C. Carter M. D.

12/4, 1930 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL 12/5/30 19

20 UNDERTAKER George J. Rush Sons — ADDRESS 1735 Harford

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62962

CERTIFICATE OF DEATH.

74 E 62962

REGISTERED NO. 12250

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO 445 E. 22nd ST. 12 WARD)

2-FULL NAME Ella Virginia Gibson

(a) RESIDENCE NO. 445 E. 22nd ST., 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Charles T. Gibson

6 DATE OF BIRTH (month, day, and year): June 27, 1877

AGE: Years 53 Months 5 Days 6 If LESS than 1 day, hrs. or min.

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country): Balto. Md. U.S.A.

PARENTS

10 NAME OF FATHER: David Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Llandiloes Wales

12 MAIDEN NAME OF MOTHER: Mary Vickers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md. U.S.A.

14 Informant (Address): Charles T. Gibson 445 E. 22nd St

15 Filed 12-4-1930, 19.. C. HARTSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28th 1930. to Dec. 3rd. 1930. that I last saw her alive on Dec 3rd, 1930. and that death occurred, on the date stated above, at 7.10 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary): Cardiac Hypertrophy

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

12/4/1930 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: Dec. 6 1930

20 UNDERTAKER: Wm. E. Black ADDRESS: 427 N. Broadway

Spec.—1-30—M. & T.—250 Bks.

243133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 62963

REGISTERED NO. E 62963

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME George Wigington

(a) RESIDENCE NO. Bedford Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Lola

6 DATE OF BIRTH (month, day, and year) Mar 25-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia Law

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed 5-1930 19 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930, to Dec 5, 1930, that I last saw h[illegible] alive on Dec 5, 1930, and that death occurred, on the date stated above, at 5 05 A. m.

The CAUSE OF DEATH* was as follows:

Progressive bulbar palsy

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 3, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Parran, M. D.

Dec 6 19 30 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bedford Va

DATE OF BURIAL 12/5/30

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 Bway

30—M. & T.—100 B—50L

E 62964

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62964

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2517 N. Schroeder ST. 18-16 WARD)

2-FULL NAME Alice Harris

(a) RESIDENCE NO 2517 N. Schroeder ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 29-1899

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	2	1	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Thomas Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elvira Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

Informant Mrs. G. Gillison

(Address) 941 W. Lafayette St

Filed 12-5-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Feller, M. D. Coroner

12/1, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lion Cemetery

DATE OF BURIAL: Dec. 5, 1930

ADDRESS 322 N. Schroeder St

20 UNDERTAKER: Mrs Katie R. Williams

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001
VE 62965

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1. PLACE OF DEATH
City of Baltimore: (No. 320 N. Carey St. 19-76 Ward)

2. FULL NAME John A. Crawmer

(a) RESIDENCE NO. 320 N. Carey St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 20, 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
		2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER John A. Crawmer

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Tennell

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant Ethel Tennell
(Address) 320 N Carey

15 Filed ... 19... HARRY JONES ... Registrar
DEC 5 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke M. D.
Dec 4. 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Dec 5, 1930
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 322 N Schroeder St

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 62966

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62966

CERTIFICATE OF DEATH.

100-09

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1129 W. Franklin ST. 18-76 WARD)

2-FULL NAME Wm. Andrew Meads

(a) RESIDENCE NO. 1129 W. Franklin ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	4	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Meads

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Dowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Gladys Bailey
(Address) 811 Edgewood St.

15 Filed 5-1930 19 _____ HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-30.

17 I HEREBY CERTIFY, That I attended deceased from 11-29-, 1930, to 12-2-, 1930, that I last saw him alive on 12-2-, 1930, and that death occurred, on the date stated above, at 11:30 A.m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(duration) yrs. _____ mos 2 ds.

CONTRIBUTORY (Secondary) Bronchitis + Jaundice

(duration) yrs. _____ mos. 5 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Frank A. Saunders, M. D.

12-3-1930 (Address) 1029 N. Strieker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Dec 5, 1930

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 322 Schroeder St

Spec.—1-30—M. & T.—250 Bks

E 62967

E 62967

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Allendale Rd ST. 15-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Phillips Weekes.

(a) RESIDENCE NO. 2108 Allendale Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Sealy Weekes.

6 DATE OF BIRTH (month, day, and year): July 15, 1841

7 AGE: Years 89 | Months 4 | Days 19 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Saml. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Matilda Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mrs Maud S. Weekes

(Address) 2108 Allendale Rd

15 Filed DEC 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1930, to Dec 4, 1930, that I last saw her alive on Dec 2, 1930, and that death occurred, on the date stated above, at 12.45a m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis Senile.
with valvular heart disease.
with aortic thickening.
(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Myocardial insufficiency
(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

12/4. 1930 (Address) 2202 Harrison.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem.

DATE OF BURIAL: Dec 6 1930

20 UNDERTAKER: Wm J Fickus Sons

ADDRESS North & Pa

Spec.—1-30—M. & T.—250 Bks.

E 62963 E 62968

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 12

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hos ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Saso

(a) RESIDENCE NO. 1406 N. Montford ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Catherine Saso

6 DATE OF BIRTH (month, day, and year): Apr 6 1859

7 AGE: Years 71 | Months 7 | Days 26 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: Penna. R. R. Balto. Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Julius Saso

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. H. Saso

(Address): 1406 Montford Ave

15 Filed ..... 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-2-30

17 I HEREBY CERTIFY, That I attended deceased from 11-23, 1930, to 12-2, 1930,

that I last saw him alive on 12-2, 1930,

and that death occurred, on the date stated above, at 9:25 A m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-27-30

Was there an autopsy? Preliminary Examination

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Dec 5 1930

20 UNDERTAKER: Wm Techner & Sons

ADDRESS: North & Pa

Spec.—1-30—M. & T.—250 Bks

62969

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 E 62969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T. B.)

CITY OF BALTIMORE: (NO. ..... ST. 17-24 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Nelson

(a) RESIDENCE NO. 937 Pennsylvania ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb. 29, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	40	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Pittsburg
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Robert Nelson

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Isabel Nelson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15a Filed 12-1 1930 C. MARSH JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1930, to Dec. 1, 1930, that I last saw him alive on Dec. 1, 1930, and that death occurred, on the date stated above, at 4.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Sommer, M. D.

12-1, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 12/5 1930

20 UNDERTAKER John J. Kelly Sons

ADDRESS 1918 Eutaw

Spec.—1-30—M. & T.—250 Bks

Laboratory

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62970

CERTIFICATE OF DEATH.

57 E 62970

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 Whittier Ave ST. 13-59 WARD)

2-FULL NAME Hanna Lebowitz

(a) RESIDENCE NO. 2212 Whittier Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Benjamin Lebowitz

6 DATE OF BIRTH (month, day, and year) Dec 28, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or .... min.
	56	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Hurdes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Nann -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis
(Address) 1431 Dale St

15 Filed 5-1930 C. HARPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH 12-4-30

16 DATE OF DEATH (month, day, and year) 12.4.30

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to Dec 4, 1930, that I last saw h[e] alive on Dec 4, 1930, and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz, M. D.

12-5, 1930 (Address) Temple Garden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Lebanon — DATE OF BURIAL 12-5-1930

20 UNDERTAKER Geo Lewis 1439 Dale St — ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 62971

CERTIFICATE OF DEATH

E 62971

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Gen. ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarubin

(a) RESIDENCE NO. 710 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 4/2/20

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Hyman Sarubin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rena Burnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mother

(Address)

15 Filed 5-1930 ELKESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4/20

17 I HEREBY CERTIFY, That I attended deceased from 12/ [illegible] 20, to 12/4/20, 19

that I last saw h[illegible] alive on 12/4/20, 19

and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Woodmen Circle DATE OF BURIAL 12-5 19 20

20 UNDERTAKER [illegible] ADDRESS [illegible]

Dr. 62972 100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 62972

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 106 S. Streeter St.) (Ward) 19-28

2-FULL NAME Capitola Aldridge
Mary Badger

(a) RESIDENCE NO. 106 S. Streeter St., Ward
(Usual place of abode) (If non-resident give city nr town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if nf foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmale	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mch 24 1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71	8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind nf work Packer
(b) General nature nf industry, business, or establishment in which employed (or employer) A. P. Gilpin Co.
(c) Name of employer Drug Co.

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Aldridge

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Storey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Miss Eva Aldridge
(Address) 1845 W Fayette

15 Filed [illegible] 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duratinn) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Brooke M. D.
Dec 4. 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths frnm Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL 12-6-1930

20 UNDERTAKER Harry A Witzke — ADDRESS 401 Edmondson Ave

DEC 6 1930 C. HAWSON JONES M. D. Registrar

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 62973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-03

E 62973

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Zieminski

(a) RESIDENCE NO. 3113 W. Garrison Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Stanley Zieminski

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Marie Dottenwich

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant John Stanley Zieminski
(Address) 3113 W. Garrison ave

15 Filed 3-1930 EDWARD JAMES JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1930, to Dec. 4, 1930,

that I last saw her alive on Dec. 4, 1930,

and that death occurred, on the date stated above, at 2.40 A.m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atresia lower end of Esophagus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? yes Date of Dec. 3, 1930

Was there an autopsy? No

What test confirmed diagnosis? Esophagoscopy

(Signed) M. B. Gilliland, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Saint Stanislaus

DATE OF BURIAL 12/5 1930

20 UNDERTAKER Stephen J. Faulkner Inc

ADDRESS 1000 N. Kenwood ave

Spec—9-30—A. & Co.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62974

CERTIFICATE OF DEATH.

62974

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1551 Lelsie ST. 15-21 WARD)

2-FULL NAME Mary Ellen Smith

(a) RESIDENCE NO. 1551 Lelsie ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, Widowed, or Divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 13-1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	15	10	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pate Hall Md

PARENTS

10 NAME OF FATHER John E Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Violet E Washington
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Gertrude Lockett
(Address) 2026 Druid St

15 Filed 5-1930 M. H. [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-27, 1930, to 12-2, 1930
that I last saw h-e alive on 12-2-30
and that death occurred, on the date stated above, at 8 a m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto md
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

(Signed) Wm R Bayless M. D.
, 19 (Address) 1512 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem
DATE OF BURIAL 12/4 1930

20 UNDERTAKER Samuel H Hensley
ADDRESS 538 W Baltimore

Form—6-9-19—H. P. Co.—1000 Blks.

E 62975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 62975

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) NO. 2411 Westwood ave 5-68 ST. WARD)

2-FULL NAME Rose Brooks

(a) RESIDENCE NO. 2411 Westwood ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hyman Brooks

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Wm Latvin
(Address) 1446 E Baltimore

15 Filed 5-1930 Per

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4th 1923, to Dec. 5th, 1930, that I last saw h alive on Dec 5th, 1930, and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Feinberg, M. D.

12/5, 1930 (Address) 2020 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 12/5 1930

20 UNDERTAKER Jos Lewis — ADDRESS 1439 E Balto St

JASON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 62976

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 62976

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Hearen St. ST. 12-14 WARD)

2-FULL NAME Alice Hersey

(a) RESIDENCE NO. 411 Hearen St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
~~HUSBAND OF~~ or) WIFE of Joseph Hersey

6 DATE OF BIRTH (month, day, and year) April 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chesterfield Va.

PARENTS

10 NAME OF FATHER Whyatt Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Joseph Hersey
(Address) 411 Hearen St

15 Filed DEC 5 1930 H. A. KELLY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1930 to Dec 3 1930, that I last saw her alive on Dec 3rd 1930, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S. Lonny, M. D.

, 19 (Address) 414 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary

DATE OF BURIAL: 12-5 1930

20 UNDERTAKER: Mrs. R. H. Elliott

ADDRESS 1725 Madison Ave

Spec.—1-30—M. & T.—250 Bks

E 62977

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 E 62977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 16-22 ST. & WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Patterson.

(a) RESIDENCE NO. 1109 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Patterson

6 DATE OF BIRTH (month, day, and year) Sept. 16 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newnonburg Va.

PARENTS

10 NAME OF FATHER Jesse Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 5-1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3-30

17 I HEREBY CERTIFY, That I attended deceased from 11-3-30, 19..., to 12-3-30, 19..., that I last saw her alive on 12-3-30, 19..., and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) yrs. mos 35 da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? Home & Hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padgett. M. D.

12-4. 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Dec 5, 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Ashland Ave

Spec.—1-30—M. & T.—250 Bks.

E 62978

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-007 E 62978

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 237 E Lafayette St. (WARD) 12-19 Stirling

2-FULL NAME Mary Bellen Stirling

(a) RESIDENCE No. 237 E Lafayette St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 67 yrs. 11 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: George S. Stirling

6 DATE OF BIRTH (month, day and year): Dec 31 1862

7 AGE — Years: 67; Months: 11; Days: 4; If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Philadelphia Penna.

10 NAME OF FATHER: David W. Sellers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Penna

12 MAIDEN NAME OF MOTHER: Emma V. Jaquet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila. Penna

14 Informant: Wm. Philip S. Stirling (son)

(Address) 237 E. Lafayette St.

15 Filed 5 DEC 1930 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-4-1930

17 I HEREBY CERTIFY, That I attended deceased from 12/1/30, 19..., to 12/4/29, 19..., that I last saw h~ alive on 12/3/30, 19..., and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) ?, yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

12/3/30 (Address) 22-E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Thomas - Garrison Ford Md. DATE OF BURIAL: Dec 5 30

20 UNDERTAKER: Stewart & Co ADDRESS: Balto.

Spec.—1-30—M. & T.—250 Bks.

E 62979

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62979

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3019 Rosalind Av (ST.) 27-5 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Estelle Robb

(a) RESIDENCE NO. 3019 Rosalind Av ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? 67 yrs. 10 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Robb

6 DATE OF BIRTH (month, day, and year): Jan 4 1863

7 AGE: Years 67 | Months 10 | Days 29 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Andrew J. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown Virginia

12 MAIDEN NAME OF MOTHER: Mary F. Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Maryland

14 Informant (Address): Mrs Nathaniel L Simpson Dayton 3019 Rosalind Av City

15 Filed C 5 - 1938 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-3-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Dec 3, 1930,

that I last saw h[illegible] alive on Dec 3, 1930,

and that death occurred, on the date stated above, at 1-15 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

on right side

(duration) ....yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) 10 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Kantner, M. D.

, 19 (Address) Glyndon Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Dec 6 19 30.

20 UNDERTAKER: Stewart & Co

ADDRESS: 108 W Monument

Spec.—2-29-28—L. F. S.—500 Bks.

E 62980 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62980

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N Pulaski ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William L Brown

(a) RESIDENCE NO. 508 N Pulaski ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: Louise Brown

6 DATE OF BIRTH (month, day, and year): June 7 1853

7 AGE — Years: 77 — Months: 5 — Days: 26 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Louise Louisa Brown (Address) 508 N Pulaski ST.

15 Filed: C 5 - 1930 By: Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 3. 30

17 I HEREBY CERTIFY, That I attended deceased from July, 1930, to Dec. 3, 1930, that I last saw h in alive on Nov. 30, 1930 and that death occurred, on the date stated above, at 7:50 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Arterio - Sclerosis chron. Int. Nephritis Mitral Decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. E. Brown, M. D.

12. 3. 1930 (Address) 516 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 12/6 30

20 UNDERTAKER: Roger A Farley

ADDRESS: Fallsway Fayette

Spec.—1-30—M. & T.—250 Blks.

E 62981

24 E 62981 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62981 31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 20-28 WARD)

2-FULL NAME Walter Bowers

(a) RESIDENCE NO. 2024 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Catherine Bowers

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant JOHNS HOPKINS HOSPITAL (Address) Baltimore

15 Filed DEC 5 1930 19 C. HAMPSON JONES, M. D. Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-28, 1930, to Dec 4, 1930, that I last saw him alive on Dec 4, 1930, and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Pneumonia-rt. lung.

Thoracoplasty & pneumothorax rt.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Post operative pneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-20-30

Was there an autopsy? no.

What test confirmed diagnosis? T.B. in sputum.

(Signed) Gordon A Cumley Cap, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/6 1930

20 UNDERTAKER Temple & Farley

ADDRESS Fulton & Fayette

Cor.—10-10-29—A Co.—100 Blks.

E 62982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 62982

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1936 E Lombard St., 2nd Ward)

2-FULL NAME Michael Pfister

(a) RESIDENCE NO. 1936 E Lombard St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Pfister

6 DATE OF BIRTH (month, day, and year) Mar 18 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	8	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schmoker
(b) General nature of industry, business, or establishment in which employed (or employer) Wards Bakery
(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Frank Pfister

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto City

12 MAIDEN NAME OF MOTHER Lost Genevive Green

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant Agatha Mackenberg
(Address) 4414 Harford ave

15 Filed 5-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest) autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What (es(confirmed diagnosis? Clinical

(Signed) James M Hinton, M. D.

12 4. 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 6th 1930
20 UNDERTAKER Lilly + Zeiler Sale	ADDRESS 400 S. Wolfe

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

62983

CERTIFICATE OF DEATH

REGISTERED NO. E 62983

1—PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. Linden & Madison ST., 19-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ada Tipton

(a) RESIDENCE NO. Mt. Airy Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 1, 1879

7 AGE: Years 51 Months 5 Days 2. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James W. Tipton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Susan Ann Covell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Hospital Records

(Address)

15 Filed 5-1930, 19 — HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 3. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22nd, 1930, to Dec. 3, 1930, that I last saw her alive on Dec 3, 1930 and that death occurred, on the date stated above, at 3:35 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral Hemorrhage

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Clinical Findings

(Signed) Robert K. Cannon, M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Cem. Mt Airy Md.

DATE OF BURIAL: 12/6 1930

20 UNDERTAKER: J. Few McCully

ADDRESS: 130 E Front

Spec. 2-29-28 L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Dr. Freedom 1031 St Paul
41-002

E 62984

REGISTERED NO. E 62984

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 W. Saratoga ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Henry Alderson

(a) RESIDENCE NO. 115 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Elizabeth Anderson Alderson

6 DATE OF BIRTH (month, day, and year) Dec. 16th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70		11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Std Shoe & Leather Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS:

10 NAME OF FATHER Wm J. Alderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Eliza Regestra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Alderson

(Address) 115 W. Saratoga St

15 Filed DEC 5 - 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1928, to Dec, 1930, that I last saw h~~im~~ alive on Dec 3, 1930 and that death occurred, on the date stated above, at 9.46 a.m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis
Cardio sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic congestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical tests

(Signed) Fran Freedom, M. D.

19 (Address) 1031 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cecilton, Md.

DATE OF BURIAL 12/6/30

20 UNDERTAKER Geo. White & Son

ADDRESS 2508 Edmondson Ave

Spec.—8-16-29—L. F. S.—100 Blks.

E 62985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

REGISTERED NO. E 62985

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. # 1107 Sargeant St. 21-29 (WARD)) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David F Dellinger

(a) RESIDENCE NO. # 1107 Sargeant St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catherine Dellinger

6 DATE OF BIRTH (month, day, and year) July 4th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	5.	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Cumberland, Md.

PARENTS

10 NAME OF FATHER John Dellinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Amanda Dellinger

(Address) 1107 Sargeant St.

15 Filed 5-1930 19... H. J. BOONE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 11/30, 19..., to Dec 4/30, 19...

that I last saw him alive on Dec 4/30, 19...

and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Paralysis (Hemiplegia) Cerebral

CONTRIBUTORY (Secondary) Artero Sclerosis, Arteriosclerosis (duration) 2 yrs. 23 mos. ds.

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John B Holt, M. D.

Dec 5/30 (Address) 20 Eagle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rose Hill Cem. Cumberland, Md. DATE OF BURIAL 12. 8 1930

20 UNDERTAKER Thos Cowan & Son ADDRESS 901 Holliday St

Spec.—1-30—M. & T.—250 Bks

62986

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 E 62986

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 20-11 WARD)

2-FULL NAME Irene Bernadine Wray

(a) RESIDENCE NO. 3334 E Balto. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Singl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 1930

7 AGE — Years | Months: 7 | Days: 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Russell Wray

11 BIRTHPLACE OF FATHER (city or town) (State or country): P.A.

12 MAIDEN NAME OF MOTHER: Rose Gorki

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Mr. Russell Wray

(Address) 3334 E Balto St

15 Filed DEC 5 1930 H. M. FOX JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1930, to Dec 5, 1930,

that I last saw h[illegible] alive on Dec 5, 1930,

and that death occurred, on the date stated above, at 3 10A m.

The CAUSE OF DEATH* was as follows:

Acute gastrointestinal indigestion

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. G. Lyon III, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lewistown P.A.

DATE OF BURIAL: Dec. 6 1930

20 UNDERTAKER: Jos. J. Herr

ADDRESS: 156 N. Lupsmeal.

Spec.—1-30—M. & T.—250 Bks

Kinsley

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62987

CERTIFICATE OF DEATH.

* 113 E 62987

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp 4-30 ST., WARD)

2-FULL NAME Robert E. Kinsley

(a) RESIDENCE NO. Guilford Howard Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	#	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Kinsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed DEC 5 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3/30.

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1930, to Dec 3, 1930, that I last saw him alive on Dec 3, 1930, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 3 mos 15 ds.

CONTRIBUTORY (Secondary) Gastrointestinal infection (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) J. Lynn Hill, M. D.

19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 12/5 1930

20 UNDERTAKER Easton Sons & Edmondson

ADDRESS

Spec.—9-30—A. & Co.—250 Bks

E. 62988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.) Home of Incurables ST. 13-52 WARD)

2 FULL NAME Emma A. Underwood

(a) RESIDENCE NO. Home of Incurables ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. S. Underwood

6 DATE OF BIRTH (month, day, and year) Feb. 4 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Fr. Muesenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) M. Hubert R. Underwood 5929 Edmondson Ave.

15 Filed 5-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 1930

17

I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1930, to Dec 4, 1930

that I last saw h alive on Dec 4, 1930

and that death occurred, on the date stated above, at 3.30 P.M. on

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (duration) 12 yrs. mos. ds.
Chronic Infections Arthritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) [illegible] M. D.

12/4/30 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL Dec. 8, 1930

20 UNDERTAKER John A. Mitchell & Son

ADDRESS 1501 Eutaw St.

Spec.—9-30—A. & Co.—250 Bks.

62989 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 62989

CERTIFICATE OF DEATH.

89

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2822 N. Calvert St. 17-50 (WARD)

2 FULL NAME Joseph S. Tate

(a) RESIDENCE NO. 2822 N. Calvert ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emily Hooper Tate

6 DATE OF BIRTH (month, day, and year) Apr 2 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
63	63.	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga. Co. Md

PARENTS

10 NAME OF FATHER Henry Tate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md E. Gilly.

12 MAIDEN NAME OF MOTHER Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Miss Hyland Tate 2822 N Calvert St

15 Filed 5-1930, 19 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1930

17 I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ Nov. 30, 1930, to Dec. 3, 1930

that I last saw h[illegible] alive on Dec 3, 1930

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John L. Tossey M. D.

19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Dec 6 1930

20 UNDERTAKER: John O. Mitchell & Son

ADDRESS: Mt. Carmel Place

Spec.—9-30—A. & Co.—250 Bks.

E 62990 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 62990

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No 5516 Groveland Ave St. 28-63 WARD)

2 FULL NAME Margaret F. Sigmon

(a) RESIDENCE No. 5516 Groveland ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry E. Sigmon

6 DATE OF BIRTH (month, day, and year) Dec 8 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Marian E. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Margaret F. Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr. Harry E. Sigmon

(Address) 5516 Groveland Ave

15 Filed DEC 5 1930 16 [illegible] Registrar

5-1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 14, 1928, to Dec 4, 1930

that I last saw h... alive on Dec 4, 1930

and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emmett K. Rabin M. D.

DEC 5 - 1930 (Address) 3005 N. Charles Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemy.	Dec. 6, 1930.
20 UNDERTAKER	ADDRESS
Edw. A. Mitchell & Sons	1906 Eutaw Pl.

Spec.—9-30—A. & Co.—250 Bks.

E 62991 HEALTH DEPARTMENT—CITY OF BALTIMORE E 62991

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH
CITY OF BALTIMORE: (No Johns Hopkins Hospital ST. 3-d WARD)

2 FULL NAME Baby Hall

(a) RESIDENCE NO. 106 S Bond ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 30 1930.

7 AGE — Years — Months 2 Days — If LESS than 1 day, ... hrs. or / min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Robert Wallace

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jeannette Hall

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant (Address) Johns Hopkins Hospital.

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar
5-1930 32553 By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-30-, 1930, to 12-2-, 1930 that I last saw him alive on 12-2-, 1930 and that death occurred, on the date stated above, at 8⁰⁰ a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aspiration pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? Yes.
What test confirmed diagnosis? —

(Signed) [illegible] M. D.
19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL DEC 3 1930

Spec.—1-30—M. & T.—250 Bks.

E 62992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 84

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 10-14 WARD)

2-FULL NAME Robert Meade

(a) RESIDENCE NO. 1218 Oakland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-3-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Meade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annette Pollard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL (Address) Meade

15 Filed DEC 5 1930 Registered No. 3252 Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3-30

17 I HEREBY CERTIFY, That I attended deceased from 12-2, 1930, to 12-3, 1930, that I last saw h...alive on 12-3, 1930, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Amyotonia congenita

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Goodwin, M. D.

12/4, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

ADDRESS

UNDERTAKER

C. HARRISON JONES, ST.

JOHNS HOPKINS HOSPITAL DEC 5 1930

Spec.—9 30—A & Co.—250 Bks

62993 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

62993

REGISTERED NO. 161-00

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2031 West Lanvale St. 11-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Boy Stauffer

(a) RESIDENCE NO. 2031 West Lanvale ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 mins ds. How Long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

8a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Sterling Stauffer

11 BIRTHPLACE OF FATHER (city or town) Carroll Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophie Virginia Arndt

13 BIRTHPLACE OF MOTHER (city or town) Berlin
(State or country) Germ

14 Informant Mrs. Sophie Virginia Arndt Stauffer
(Address) 2031 West Lanvale St

15 Dec 5 - 1930 19 C. HAMPSON JONES, M. D.
Registrar

5254

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1930, to Dec 4, 1930

that I last saw him alive on Dec 4, 1930

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
at Birth.
Lived 20 min.

(duration) 20 mins

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of See Reverse Side

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Joshua H. Armacost M. D.

Dec 4, 1930 (Address) Woodlawn, Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner of Health.
DEC 5 - 1930

Cor.—10-10-20—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 62994

74-001

E 62994

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 233 S Hilton St. (Ward) 20-70

2-FULL NAME Mincya E Bosley

(a) RESIDENCE NO. 233 S Hilton St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Divorced

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Abram Bosley

6 DATE OF BIRTH (month, day and year) Sept 13-1884

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
46	2	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Conrad Gale

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ida Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs. Mincya Bosley
(Address) 233 S. Hilton St.

15 Filed Dec 5 1930 C. HANSON JONES, M. D. Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke, M. D.

Dec 5. 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	12-6 1930
20 UNDERTAKER	ADDRESS
Wm. Cahill & Son	

IMPORTANT. See instructions on back of certificate. FILL OUT DEATH IN plain letters, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Bks.

E 62995 ✓ E 62995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 14-27 WARD)

2-FULL NAME John Lloyd

(a) RESIDENCE NO. 443 S. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) City work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Hugh Dunn

(Address) 443 S. Stricker St.

Filed 5-1930 C. MARSON JONES, M. D. Registrar

By RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/3/30

17 I HEREBY CERTIFY, That I attended deceased from 11/28, 1930, to 12/3, 1930

that I last saw him alive on 12/3, 1930

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Malignant Hypertension.

6-Chronic Glomerular Nephritis

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Cardiac Degen. & Decomp.

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Hyalmar S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec. 6th 1930

20 UNDERTAKER A. Jones

ADDRESS 111 N. Gilmor

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62996 ✓ E 62996

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 440 N. Fremont St. (or WARD) 18-21

2-FULL NAME Louise Boone

(a) RESIDENCE No 440 N. Fremont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Foster

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant J. Carroll Boone
(Address) 1219 Eutaw Land Ave

15 Filed 5-1930 16 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Dec 5, 1930, that I last saw h[illegible] alive on Dec 4, 1930, and that death occurred, on the date stated above, at 145 am.

The CAUSE OF DEATH* was as follows:

Hepatic Congestion - Senility

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J Mooney M. D.

12/5, 1930 (Address) 51 N. Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 8 1930
20 UNDERTAKER	ADDRESS
Herman Kellner	632 Hollins

IMPORTANT.—See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 62997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

191 E 62997

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Providence Hosp. (ST.) 11-24 (WARD)

2-FULL NAME Theo. Maxwell

(a) RESIDENCE NO. 1124 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Maxwell

6 DATE OF BIRTH (month, day, and year) Nov 6 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rome Ga.

PARENTS

10 NAME OF FATHER Edward Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Elenie Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Edward Maxwell

(Address) 1129 McCulloh

15 - 1930 C. THAMPSON JONES, M. D. Registrar

Dat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1930

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pistol wound of Chest (duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1124 mc Culloh

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Leland Mackenzie M. D. Coroner

(Address) Coroner

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carter's Ville Ga

DATE OF BURIAL Dec 7 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

Cor.—10-10-29—A Co.—100 Bks.

E 62998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

186-002 ✓ E 62998

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Franklin Sq Hosp. (Ward) 15-6

2-FULL NAME Alford E Johnson

(a) RESIDENCE NO. 2005 E. Madison St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Kath. Johnson

6 DATE OF BIRTH (month, day, and year) Sept 6 - 1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alfred Johnson

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Foller

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

14 Informant Mrs Johnson (Address) 200 N Monroe

15 Filed 5-1930 O. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy (or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: due to he was driving collided with fleet car causing his auto to collide with pole

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Comp. Com. Frac. Fragmentary of left Tibia & Fibula (duration) yrs. mos. da.

Where was disease contracted if not at place of death? 2700 block Liberty H.

Did an operation precede death? yes Date of Operation Dec 4

Was there an autopsy? no

What test confirmed diagnosis? Clin & Surg.

(Signed) J J Frame, M. D.

12/5 1930 (Address) 2101 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/6 1930
20 UNDERTAKER Geo E Kemp	ADDRESS Lafayette

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 62999

100-001

E 62999

CERTIFICATE OF DEATH

REGISTERED NO. 15558

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3127 Park Heights Ave. (St.) (W.(RD)

2—FULL NAME Herman Stern

(a) RESIDENCE NO. 3127 Park Heights Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Stern

6 DATE OF BIRTH (month, day, and year) July 23/1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER L. Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ? Isenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. E. Mendes (Address) 3127 Park Heights Ave.

15 Filed ... 19 ... AT ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4/1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1930, to Dec. 4, 1930, that I last saw him alive on Dec. 4, 1930 and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isaiah Wolmon, M. D.

Dec 1-5, 1930 (Address) 2444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cemetery

DATE OF BURIAL Dec 7/1930

20 UNDERTAKER J. Schnorf

ADDRESS 2432 Reisterstown Rd

5-1930

E 63000

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63000

CERTIFICATE OF DEATH

101-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 Smith St. 14-20 WARD)

2-FULL NAME Augustus Ball

(a) RESIDENCE NO 646 Smith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ....

6 DATE OF BIRTH (month, day, and year) Aug 12-1926

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ernest Ball

11 BIRTHPLACE OF FATHER (city or town) (State or conntry) Md.

12 MAIDEN NAME OF MOTHER Pauline White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mother (Address) 646 Smith St.

15 JUN 3 1930 Filed ....., 192 ..... Per ..... C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... Coroner, M. D.

(Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 12-6 1930

20 UNDERTAKER Daniel Carlon

ADDRESS 916 Pa Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63001

CERTIFICATE OF DEATH.

E 63001

REGISTERED NO. 28-64 118-02

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4406 KATHLAND AVE (St.) (Ward) 28

2-FULL NAME ROSE BARBARA McCABE

(a) RESIDENCE NO. 4406 KATHLAND AVE ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 2 mos. 29 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver L. McCabe

6 DATE OF BIRTH (month, day, and year) SEP. 6 1890.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	40	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) National City Iowa

PARENTS

10 NAME OF FATHER Irwin Knuth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Oliver L. McCabe (Address) 4406 Kathland Ave.

15 Filed DEC 8 1930, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from OCT. 21, 1930, to DEC 5, 1930,

that I last saw h[illegible] alive on DEC. 5, 1930,

and that death occurred, on the date stated above, at 6:20 A m.

The CAUSE OF DEATH* was as follows:

ACUTE INTESTINAL OBSTRUCTION.

(OPERATION FOR ENTEROSTOMY)

(duration) — yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) ACUTE NEPHRITIS

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of OCT. 21, 1930.

Was there an autopsy? NO

What test confirmed diagnosis? Clinical Symptoms.

(Signed) [illegible], M. D.

, 19 (Address) 18 East Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westorn Cemetery

DATE OF BURIAL 12/8 1930

20 UNDERTAKER H. B Fanning Sons & Baldwin

ADDRESS 1136

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 63002

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63002

CERTIFICATE OF DEATH

90

REGISTERED NO. 15-63

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3902 Dorchester Rd ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Fastenia Wickliffe

(a) RESIDENCE NO. 3902 Dorchester Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Andrew J. Wickliffe

6 DATE OF BIRTH (month, day, and year) Feb 18th 1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward W.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Grahame

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Cora Lee Berger

(Address) 3902 Dorchester Rd

15 Filed 5-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Dec 5, 1930, that I last saw h[illegible] alive on Dec 5, 1930 and that death occurred, on the date stated above, at 10.46 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard F. Warner, M. D.

12-5, 1930 (Address) 2 E Barrow Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 12/8/1930

20 UNDERTAKER Wm Cook 1217 St Paul St

ADDRESS

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Houck North Ave & Appleton St

E 63003

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 63003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2041 W. North Ave (St.) 45-31 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella V. Stouffer

(a) RESIDENCE NO. 2041 W. North Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Charles Stouffer

6 DATE OF BIRTH (month, day, and year) July 2nd 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) New Windsor Carroll Co Md

PARENTS

10 NAME OF FATHER Jesse Dr Vilbiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Windsor Md

12 MAIDEN NAME OF MOTHER Catherine Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Windsor Md

14 Informant Catherine E Shields

(Address) 2041 W. North Ave

15 Filed 5-1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 1930, 19..., to ..., 19..., that I last saw her alive on Dec 4 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Carcinoma Abdomen

Do not know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted? V

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Y

What test confirmed diagnosis?

(Signed) ..., M. D.

Dec 5 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 12/8/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE IS very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 63004 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63004

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 E 32nd. ST. 9-46 WARD)

2-FULL NAME John Rudge Hare

(a) RESIDENCE NO. 1631 E. 32nd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. M. Hare

6 DATE OF BIRTH (month, day, and year) April 21st. 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER James Hare

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Hannah Rudge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Miss Hare

(Address) 1631 E. 32nd. St.

15 Filed 5-1930 C. HAMPSON JONES, M. D. Registrar

By R.R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4—1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1930 to Dec 4, 1930

that I last saw h[illegible] alive on Dec 4, 1930

and that death occurred, on the date stated above, at 10.0 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Agn. Heart & Cardio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Forsyth M. D.

12-5 1930 (Address) 119 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 12/8 1930

20 UNDERTAKER Chas P. Evans & Son ADDRESS 118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 63005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 63005

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 E. Franklin St. ST. 4-7 WARD)

2-FULL NAME William E. Lane.

(a) RESIDENCE NO 13 E. Franklin St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John J. Lane.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Barbara Keyser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Martin Fahey.

(Address) 1318 Light St.

15 DEC 5 1930

C. HARRISON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 3, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No!

What test confirmed diagnosis? Inquiry

(Signed) Otto Hemhard, M. D. Coroner

12/5, 1930 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cem

DATE OF BURIAL 12/6 1930

20 UNDERTAKER J. H. Lahey & Sons

ADDRESS 1318 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. If uncertain, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 63006

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 Woodland Ave. St.; 37-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mayme M. Kemp.

(a) RESIDENCE. No. 2317 Woodland Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles M. Kemp

6 DATE OF BIRTH (month, day, and year) May 16, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Rachel Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hagerstown Md.

14 Informant Charles M. Kemp
(Address) 2317 Woodland Ave

15 Filed . 19 C. HAMPSON JONES, M. D.
Registrar

C 5 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to Dec. 2, 1930, that I last saw her alive on Dec. 2, 1930, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast with metastasis to right lung and glands of Thoracic Cavity (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Study

(Signed) James L. Akehurst, M. D.

(Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	12/6 1930
20 UNDERTAKER	ADDRESS
C. Vernon Lemmon	4611 Park Heights Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DYING is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63007

CERTIFICATE OF DEATH

101-01

E 63007

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 514 N. Central Ave St. 5-8 Ward)

2-FULL NAME Ella Green or Thompson

(a) RESIDENCE NO. 514 N. Central Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	black	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of xxxxx Thompson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Adele Green (niece)
(Address) 423 N. Spring St

15 Filed ..., 19... HARRISON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec4/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted Unknown
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Dec 5 19 30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern cemetery Dec 7 19 30

20 UNDERTAKER Milton Davis

ADDRESS 413 N Eden St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C 6 1930

Spec.—1-30—M. & T.—250 Bks.

E 63008

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63008

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6-9 WARD)

2-FULL NAME ~~Hazel~~ HAZELTINE McCullough

(a) RESIDENCE NO. 300 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced, (~~write the~~ word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of Allen McCullough

6 DATE OF BIRTH (month, day, and year) June 18, 93

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Shelton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sally Cullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Records

Filed 6-1930, 19 .. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 4/30

17 I HEREBY CERTIFY, That I attended deceased from December 1, 1930 to December 4, 1930, that I last saw her alive on December 4, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 300 N. Broadway

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Blood Studies & Phys. Exam

(Signed) Caroline C. Bedell, M. D.

12/4, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	12-8-30
20 UNDERTAKER E & B Harle 115 E	ADDRESS West St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

12-31-30 E 63009-c

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002 E 63009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Johnson

(a) RESIDENCE NO. 214 So. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer O&D

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jack Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed 19 C. HAMPSON JONES, M.D. Registrar

C 6-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4-30

17 I HEREBY CERTIFY, That I attended deceased from 12-1, 19 30, to 12-4, 19 30, that I last saw h[illegible] alive on 12-4, 19 30, and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12-2-30

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation.

(Signed) I. B. Taylor M.D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery Cemetry — DATE OF BURIAL 12-7-30

20 UNDERTAKER P. E. Wilkinson — ADDRESS 1515 McCulloh St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 63010

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jenkins Memorial Hospital REGISTERED NO. 23-72

CITY OF BALTIMORE: (No.) 1000 Caton Ave. ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Little

(a) RESIDENCE NO. Emmitsburg Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Emmitsburg Maryland

PARENTS

10 NAME OF FATHER Bernard Little

11 BIRTHPLACE OF FATHER (city or town) (State or country) Emmto. Maryland

12 MAIDEN NAME OF MOTHER Laura Biddicord

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emmitsburg Maryland

14 Informant (Address) Jenkins Mem. Hosp. 1000 Caton Ave

15 Filed ... 19 ... C. HARRISON JONES, M. Registrar

Dec. 6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from November 29, 1930, to December 6, 1930, that I last saw him alive on December 5, 1930, and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary) Frederick Arteria

(duration) 15 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Hickman S Amason, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. St Mary's, Emmitsburg, Md.

DATE OF BURIAL Dec. 6 1930

20 UNDERTAKER Wm. F Shuff Jr. Emmitsburg Md.

ADDRESS

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 63011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 63011

REGISTERED NO. 167-80/32

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital St., 10-12 Ward)

2-FULL NAME Martha Thomas

(a) RESIDENCE NO. 2112 Eagle St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry C. Thomas

6 DATE OF BIRTH (month, day, and year) Sept 28 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Jos. Simpson

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Dora Schanarty

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Henry C. Thomas
(Address) 2112 Eagle St

15 Filed ... C. HAMPSON JONES, M. D. Registrar

C 6-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide. Asphyxiation from illuminating gas at home
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O. Brooke M. D.
Dec 6, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Dec 8 1930

20 UNDERTAKER George L. Schwartz — ADDRESS 2101 Fulk Ave.

Tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 63012 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63012

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 16-22 WARD)

2-FULL NAME George S Osborne

(a) RESIDENCE No. 1802½ W. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. Ada Osborne

6 DATE OF BIRTH (month, day, and year) Sept. 11, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired R.R. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad Employee

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Pittsburgh, Pa.

PARENTS

10 NAME OF FATHER Thomas J. Osborne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Alice Johnstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. M. Ada Osborne (Wife)

(Address) 1802½ W. Lafayette Ave.

15 Filed DEC 6 - 1930, 19 C. HARRISON JONES, M. D. Registrar

RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1930, to Dec. 4, 1930, that I last saw him alive on Dec. 4, 1930, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Renal, and hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical observation

(Signed) Wylie M. Fall, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Park Wood	Dec 8 1930
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

Coroner's Inquest, H. D. Caverly, M.D.

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 63013

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63013

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. ..... WARD)

2-FULL NAME Edward I. Henderson.

(a) RESIDENCE No. 2904 Union Ave. Altoona, Pa. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced.

5a If ~~married, widowed or divorced~~ HUSBAND of (or WIFE of) ~~XXXXXXXX~~ Josephine Henderson.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrical Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer) 030
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Louis Henderson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Alice Isett.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Dr. Ernest J. Hoover.

(Address) 2901 Union Ave. Altoona, Pa.

15 Filed 6-[illegible]-1930 19[illegible] [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) December 4, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1707 N. Charles St. December 4. 1930

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D. Coroner

12/6, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Altona Penna

DATE OF BURIAL 12/6 1930

20 UNDERTAKER For A Farley

ADDRESS 1800 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 63099 — E 63014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. ..... WARD) 76-20

2-FULL NAME Walter Zander

(a) RESIDENCE NO. 306 North Point Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8-29-30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Walter Zander

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Della Breck

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed DEC 6 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1930 to Dec 4, 1930
that I last saw him alive on Dec 4, 1930
and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Bronco-pneumonia

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) Amalentitis

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. L. London, M. D.

12/4, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London PR

DATE OF BURIAL Dec 6 1930

20 UNDERTAKER Philip Henrig

ADDRESS 2016 Eden St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 63015 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 N. Curley ST. 7-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Peters.

(a) RESIDENCE NO. 813 N. Curley St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced (~~HUSBAND of~~ or) WIFE of Frank Peters.

6 DATE OF BIRTH (month, day, and year) March 12. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer) ~~✓~~ 037

(c) Name of employer ~~✓~~

9 BIRTHPLACE (city or town) (State or country) Langfelt. Germany.

PARENTS

10 NAME OF FATHER Cristian Biel.

11 BIRTHPLACE OF FATHER (city or town) Langfelt. (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Frank ~~Peters~~ Peters.

(Address) 813 N. Curley St.

15 Filed DEC 6-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1920, to Dec. 5, 1930, that I last saw her alive on Dec. 5, 1930, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 7 mos da.

CONTRIBUTORY (Secondary) Asthma.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray.

(Signed) Wm Schmidt, M. D.

12/7, 1930 (Address) 701 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Dec. 8, 1930

20 UNDERTAKER August Paseck ADDRESS 2406 E. Ashland Ave.

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63016

100-901

E 63016

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 15-21 WARD)

2-FULL NAME Susie Barber

(a) RESIDENCE NO. 1541 N. Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John

6 DATE OF BIRTH (month, day, and year) May 21, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co. Md.

PARENTS

10 NAME OF FATHER Harry Barber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Letty Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records of Balto. City Hosp.

15 Filed 6-1930 19 C. HARRISON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-30

17 I HEREBY CERTIFY, That I attended deceased from 9-30-30, 19, to 12-5-30, 19, that I last saw her alive on 12-5-30, 19, and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Pemphigus (duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical exam; autopsy

(Signed) Paul Padget, M. D.

12-6, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL 12/8 1930

20 UNDERTAKER C. C. Wright

ADDRESS 700 Carrollton

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

63017

E 63017 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. + 124

E 63017

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary WARD) 9

2-FULL NAME Mrs. Margaret E. Legg.

(a) RESIDENCE NO. Stevensville, Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh A Legg.

6 DATE OF BIRTH (month, day, and year) March 19 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliz Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hugh A Legg Md.

(Address) Stevensville Md.

15 Filed Dec 7 1930, 19 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from October 24, 1930, to December 6, 1930,

that I last saw h[illegible] alive on December 6, 1930,

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chronic Pancreatitis; chronic cholecystitis and cholelithiasis; cholicystectomy (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Thrombophlebitis, L Leg (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of November 3, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Clinical course

(Signed) Oscar E. Hubbard - 409 Cornwall St.

Dec. 6, 1930 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stevensville Md

DATE OF BURIAL 12-7 1930

ADDRESS

20 UNDERTAKER Bernard C. Hadaway 000 S Paca St

TION is very important. See instructions on back of certificates.

Spec.—9-30—A. & Co.—250 Bks.

E 63018

E 63018

E 63018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90 E 63[illegible]8

1. PLACE OF DEATH Mrs. Silling's Home. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 38-71 Rodwood Heights ST. WARD)

2. FULL NAME Margaret J. L. Breugle

(a) RESIDENCE NO. Rodwood Heights ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Breugle

6 DATE OF BIRTH (month, day, and year) Sept 27. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Henry Heet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mookenda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. & Mrs. H Breugle
(Address) Rodwood Md

Filed 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930, to Dec. 5, 1930

that I last saw h[illegible] alive on Dec 5, 1930.

and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

1 Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. Fleming M. D.

12/5 1930 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Frederick Md DATE OF BURIAL Dec 8 1930

20 UNDERTAKER John O Mitchell & Sons. ADDRESS 1410 Eutaw Place

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63019

CERTIFICATE OF DEATH.

49

REGISTERED NO. E 63019

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South West Gen Hosp ST., 13-59 WARD)

2-FULL NAME Thomas A Smith

(a) RESIDENCE NO. 2527 Pennsylvania ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July — 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	17		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Earl Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lola Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hosp. Records (Address) So. Balto. Gen

15 Filed DEC 7 - 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1930, to Dec 6, 1930, that I last saw him alive on Dec 6, 1930, and that death occurred, on the date stated above, at 4:25 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of cerebrum

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 17. 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Pathologic section

(Signed) Wm O. Sullivan M. D.

, 19 (Address) So Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Soldiers Md	12/7/30
20 UNDERTAKER Harry A Dietz	ADDRESS 4101 Edmondson

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 63020

188-103

E 63020

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Mem Hos St. 43-53 Ward)

2-FULL NAME Nellie Hpperaul

(a) RESIDENCE NO. 618 N. 33rd St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Wm H Hpperaul

6 DATE OF BIRTH (month, day, and year) July 9 — 1880.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50	4	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hwk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Wm H. Hpperaul
(Address) 618 N 33rd St.

15 Filed [illegible] HENRY JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & knocked down by moving auto

(a) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Park Ave & Mt Royal

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H J Haase M. D.

12/6, 1930 (Address) 2934 Mt Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hampden	Dec 9 1930
20 UNDERTAKER Chesmore & Low	ADDRESS 30 W Lanvale St

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63021

E 63021

CERTIFICATE OF DEATH

162

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Johns Hopkins Hospital St. 12-51 Ward)

2-FULL NAME Albert F. Cockey

(a) RESIDENCE NO. 2831 Bernard St St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1/30

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Albert S. Cockey

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Gladys Cooke

13 BIRTHPLACE OF MOTHER (city or town) Canada
(State or country)

14 Informant Albert S. Cockey
(Address) 2831 Bernard St

15 Filed DEC 7 - 1930 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Icteris Gravis-Hemorrhage of New Born.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. H. Cocey, M. D.

Dec. 6/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem

DATE OF BURIAL Dec 7 1930

20 UNDERTAKER Chenowith & Son

ADDRESS 3615 Gliston Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—9-30—A. & Co.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63022

CERTIFICATE OF DEATH.

11-00 63022

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 3718 Chestnut Ave (WARD) 3-52

2 FULL NAME James L. Ray (Jr.)

(a) RESIDENCE NO. 3718 Chestnut Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22/1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER James Ray Md.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lizzie Cotter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Lenar Ray
(Address) 3718 Chestnut Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-5, 19 30, to 12-5, 19 30

That I last saw h[illegible] alive on 12-5, 19 30

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Locomotor

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. T. Chaplin M. D.

12-23, 19 30 (Address) 3701 Reisterstown Rd

*State the Disease Causing Death, or In deaths from Violent Causes State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Dec 9, 19 30

20 UNDERTAKER Chenowith & Son

ADDRESS 3615 Chestnut Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Thostrup 888 W. Lombard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63023

CERTIFICATE OF DEATH.

21

E 63023

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1221 Jaines St ST. 21-29 WARD)

2-FULL NAME Otto G. Kraus

(a) RESIDENCE NO. 1221 Jaines ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26th 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Kraus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Gastel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Kraus

(Address) 888 W. Lombard St

15 Filed 1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Dec 6, 1930, that I last saw h[illegible] alive on Dec 6, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam Etc

(Signed) C. H. Thostrup, M. D.

12/6, 19 30 (Address) 888 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 12/9 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Kourey 1812 N. Broadway ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 63024

CERTIFICATE OF DEATH.

+ 90

E 63024

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2539 Garrett Av ST., 9-46 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Pratt

(a) RESIDENCE NO. 2539 Garrett Ave ST., WARD Vacant

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If (married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 1st 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Clyde W Halstead

(Address) 245 W. 31st St Norfolk Va

15 Filed Dec 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1930, to Dec 6, 1930, that I last saw h.m alive on Dec 6, 1930, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. W Kourey, M. D.

, 19 (Address) 1812 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va.

DATE OF BURIAL 12/6/1930

20 UNDERTAKER Wm Cook

ADDRESS 127 St Paul St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 63025

REGISTERED NO. E 63025

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 16-23 Ward)

2-FULL NAME Edward R. Akers

(a) RESIDENCE NO. 705 Arlington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 21/ 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particolar kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Erfel E. Akers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) SALTVILLEVA

12 MAIDEN NAME OF MOTHER Mildred Wallace

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Erfel E. Akers
(Address) 705 Arlington Ave

15 Filed C. HARRISON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:
Cardiac Failure following ether anaesthesia and eye enucleation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) On nov 7th., a playmate accidently threw a feather dart into eye

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes Dec 5/30

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

Dec 6/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 8 1930
20 UNDERTAKER Geo Schilling & Sons	ADDRESS Greenmount Cemetery

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63026

CERTIFICATE OF DEATH.

90

E 63026

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 27-55 WARD)

2-FULL NAME Jacob Cohen

(a) RESIDENCE NO. 3702 Glen Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur for

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Ben. Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Russia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Lewis (Address) 1439 E Lafayette St

15 Filed 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-30

17 I HEREBY CERTIFY, That I attended deceased from 10-20-, 1930, to 12-7, 1930, that I last saw him alive on 12-7, 1930, and that death occurred, on the date stated above, at 6:10 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (Type undetermined)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 14 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dutton B Kirsh, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levy Woodlawn — DATE OF BURIAL 12-7-1930

20 UNDERTAKER Jac L Lewis, 1439 E Lafayette St. — ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63027

CERTIFICATE OF DEATH.

90 E 63027

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 15-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Lucchesi

(a) RESIDENCE NO. 4000 Belvieu Ave ST., WARD

(Usual place of abode)

(if non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clotilda Fink

6 DATE OF BIRTH (month, day, and year) -------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer First National Bank

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Frederick Lucchesi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Ellen Howe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Clotilda F. Lucchesi

(Address) 4000 Belvieu Avenue

15 Filed 19 C. HARRISON JONES, M. D. Registrar

DEC 7 - 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from 11-12, 1930, to 12-5, 1930, that I last saw him alive on 12-5, 1930, and that death occurred, on the date stated above, at 8.35 p. m.

The CAUSE OF DEATH* was as follows:

① Benign hypertrophy of prostate with urinary retention ② Chronic myocarditis ③ Chronic bronchitis

(duration) 5 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia, bilateral

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11-28-30

Was there an autopsy? No

What test confirmed diagnosis? Phys. signs, symptoms, lab work.

(Signed) L. Stone Baker, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/9 19 30

UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 63028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

183 ✓ E 63028

REGISTERED NO. 25-77

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General Hospital ST. WARD

2-FULL NAME George Huber.

(a) RESIDENCE No. 5722 Pennington Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) June 8, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Chauffeur.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Paul Huber.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Helwig.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Paul Huber. (father)

(Address) 5722 Pennington Ave.

15 Filed Dec 1 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental rifle shot wound of the chest. Traumatic Pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 5722 Pennington Ave. Dec. 2, 1930

Did an operation precede death? Yes. Date of Dec. 2, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto Reinhard, M. D. Coroner

12/5 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Dec. 8 1930

20 UNDERTAKER: Margaret J. Flynn — ADDRESS: 1111 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 63029 ✓ 90 E 63029

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Edythe ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Williams

(a) RESIDENCE NO. 1225 Edythe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Williams

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Benj Grimage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ella Williams

(Address) 1225 Edythe St

15 Filed DEC 7-1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1930, to Dec 3, 1930,

that I last saw h.r alive on Dec 3 1930

and that death occurred, on the date stated above, at 10 40 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 6 yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edward Fisher M. D.

12-6. 1930 (Address) 1612 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL Dec 7 1930

20 UNDERTAKER Mrs B.E. Elliott

ADDRESS 1725 Ashland ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63030

CERTIFICATE OF DEATH.

100-001

E 63030

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 13-57 WARD)

2-FULL NAME Andrew Tawney

(a) RESIDENCE NO. 3730 Falls Rd. Hampden WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Tawney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Lockard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs James Tawney

(Address) 3730 Falls Rd Hampden

Filed DEC 7 - 1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7/30

17 I HEREBY CERTIFY, That I attended deceased from 11/27/30, 1930, to 12/7/30, 19

that I last saw h/ alive on 12/7/30, 19

and that death occurred, on the date stated above, at 12 [illegible] a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lawrence M. Dietz M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Lutheran

DATE OF BURIAL 12/10 1930

20 UNDERTAKER H Barkhardt & Son

ADDRESS Westminster Md

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 63031 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63031

CERTIFICATE OF DEATH.

+ 73

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. ..... WARD) 47

2-FULL NAME John L Winkler

(a) RESIDENCE NO. Pomfret, Chas Co., Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 62 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Helen Winkler

6 DATE OF BIRTH (month, day, and year) June 29 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	35	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Leonards Co Md

PARENTS

10 NAME OF FATHER Anthony Winkler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emily Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Hospital Record
(Address)

15 Filed 7 1930 19 C. LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-30

17 I HEREBY CERTIFY, That I attended deceased from 12-3, 1930, to 12-7, 1930, that I last saw h[illegible] alive on 12-7, 1930, and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Transverse Myelitis

approx. 12 days (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Acute Nephritis

? (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

12/7, 1930 (Address) Mercy Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorsey Pomfret Md.

DATE OF BURIAL 12/8 1930

20 UNDERTAKER Walter Davis

ADDRESS 3618 Eastern Ave

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 63032

CERTIFICATE OF DEATH.

E 63032

REGISTERED NO. E 63032

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. 8-7 WARD)

2-FULL NAME Alvin Gale Wilson

(a) RESIDENCE NO. 1509 N. Wolfe ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 21st 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Bert Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Elsie Crass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Towson

14 Informant Elsie Wilson

(Address) 1509 N. Wolfe St

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

C 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1930, to Dec 6, 1930,

that I last saw h alive on Dec 6, 1930,

and that death occurred, on the date stated above, at 7:20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Pneumococcic Cerebrospinal Meningitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory & Clin. findings

(Signed) John G. Lynn III, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 12/8/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63033

CERTIFICATE OF DEATH.

91-002

E 63033

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 12-5D WARD)

2-FULL NAME Overton D. Kent

(a) RESIDENCE NO. 3025 Abell Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth D. Kent

6 DATE OF BIRTH (month, day, and year) Sept 9-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Lee Kent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice M. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Elizabeth D. Kent

(Address) 3025 Abell Ave

15 Filed DEC 8 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3. 1930. to Dec. 5 1930.

that I last saw him alive on Dec 5 1930.

and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis & Hypertension

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical observation & lab tests.

(Signed) L. G. Tyson, III, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 12/9 1930

20 UNDERTAKER Chas. S. Frank & Son

ADDRESS 118 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63034

CERTIFICATE OF DEATH.

E 63034

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (Tbc.)

CITY OF BALTIMORE: (No. ..... ST. 4-25 ..... WARD)

2-FULL NAME Chin Jong

(a) RESIDENCE NO. 212 W. Mulberry st. ST., ... WARD .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Unknown yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Yellow	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Win Oye

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Chin Winn

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Win Si

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Hospital Records
(Address)

15 Filed DEC 8 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 9 19 30, to Dec. 5 19 30, that I last saw him alive on Dec. 5 19 30, and that death occurred, on the date stated above, at 5.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary) Intestinal tuberculosis

(duration) ..... yrs. ..... mos. ..... ds. Unknown

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jenner, M. D.

12-5 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 8 19 30
20 UNDERTAKER Stewart & Company	ADDRESS 19 Warren Ave

TION is very important. See instructions on back of certificates.

C

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63035

E 63035

CERTIFICATE OF DEATH

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1216 N. Calvert St. 11-15 Ward)

2-FULL NAME Margaret Murphy

(a) RESIDENCE NO. 1216 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Timothy Murphy

6 DATE OF BIRTH (month, day, and year) --------

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	71	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John T. O'Halloran

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Abbey Dorgan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Catherine P. O'Halloran
(Address) 1216 N. Calvert Street

15 Filed ..... 1930 C. HAMPSON JONES, M. D., Registrar

For Gill

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism (Embolism)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W. H. Peters, M. D.

Dec. 8, 1930 (Address) 1139 Bmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/9 1930

20 UNDERTAKER Henry W. Meade & Son

ADDRESS 1216 N. Calvert

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63036

CERTIFICATE OF DEATH

179 ✓ E 63036

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp. ST. 14-59 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Williams

(a) RESIDENCE NO 514 Bloom ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year) Nov 17 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Albert Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): S Carolina

12 MAIDEN NAME OF MOTHER Estella Williamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Lloyd Williams

(Address): 514 Bloom

15 Filed Dec 8 1930 12 C. HAMPSON JONES, M. D. Registrar 43

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1930.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd Degree burns

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Not while full Work by

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D. Coroner

(Address) Bozare

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Dec 8 1930

20 UNDERTAKER: Thomas E Kelson — ADDRESS: 1303 Pennsylvania Ave

Spec—1-30—M. & T.—250 Blks

E 63037.

E 63037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-001

E 63037

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 3-5 WARD)

2-FULL NAME Issac Glick.

(a) RESIDENCE NO. 22 S. Hugh Street ST., ... WARD .....
((Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 43 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 20. 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	0 11	0 7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Russia~~ Ohio

PARENTS

10 NAME OF FATHER Henry Glick

11 BIRTHPLACE OF FATHER (city or town) Russia.
(State or country)

12 MAIDEN NAME OF MOTHER Minnie ?

13 BIRTHPLACE OF MOTHER (city or town) Russia.
(State or country)

14 Informant Hospital record.
(Address)

15 Filed 8 1930, 19 ... C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1930, to Dec 7, 1930, that I last saw him alive on Dec 7, 1930, and that death occurred, on the date stated above, at 9 05 A m.

The CAUSE OF DEATH* was as follows:

History of alcoholism, enlarged liver with general ascites, oesophageal hemorrhages. (Alcoholic Cirrhosis of liver)

? (duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) oesophageal hemorrhage ? (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) J. H. Gardner, M. D.

12/7, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 12-5 1930

20 UNDERTAKER Jac R Levin

ADDRESS 1719 E Pratt

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63038 74-004 E 63038

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 204 Augusta ave. 70-71 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Stinefelt

(a) RESIDENCE NO. 204 Augusta St., Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia E. Stinefelt

6 DATE OF BIRTH (month, day, and year) Feb. 7th 1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	9	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work B.&O. Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) 673
(c) Name of employer Md.

9 BIRTHPLACE (city or town) _____
(State or country) Md.

PARENTS

10 NAME OF FATHER Benj Stinefelt

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Shuster

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Ger

14 Informant Julia E. Stinefelt
(Address) 204 Augusta ave

15 Filed DEC 8 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc. of Injury

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Chas. F. Brooks M. D.

Dec 6 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec. 9 1930
20 UNDERTAKER	ADDRESS
George L. Schwartz	201 Fulton Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 63039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 63039

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 8-16 WARD)

2-FULL NAME Mary Dena Wick

(a) RESIDENCE NO. 1914 Brailman Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX white | 4 COLOR OR RACE female | 5 Single, Married, Widowed, or Divorced, (write the word) ✓

5a If married, widowed, or divorced HUSBAND of or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May-16-1930

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
		6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Wick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Gertrude Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John Wick (Address) 1914 Brailman Place

15 Filed DEC 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6-1930

17 I HEREBY CERTIFY, That I attended deceased from 11-19-30, 19..., to 12-6, 1930, that I last saw her alive on 12-6-30, 19..., and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia and Atelectasis

(duration) ... yrs. ... mos 18 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical autopsy

(Signed) Lawrence McSena, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hospitals

DATE OF BURIAL Dec 8 1930

20 UNDERTAKER Geo M. Funk & Son

ADDRESS 811 N Howard St

(1) FILL IN ALL ITEMS—(2) IF NOT KNOWN, STATE SO—(3) INFORMATION IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63040

CERTIFICATE OF DEATH.

101-001

E 63040

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hosp. ST. 7-4 WARD)

2-FULL NAME Mrs. Frances Malanowski

(a) RESIDENCE NO. 1722 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wallace Malanowski

6 DATE OF BIRTH (month, day, and year) Aug-10, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records (Address)

15 Filed DEC 3 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-30

17

I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1930, to Dec 7, 1930, that I last saw h e alive on Nov. 29, 1930, and that death occurred, on the date stated above, at 6:40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Lung Abscess

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Thomasville

Did an operation precede death? Yes Date of Dec 5, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Obs

(Signed) J Feghi, M. D.

12/7, 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 11 1930
20 UNDERTAKER	ADDRESS
Peter M Weber	1011 Wilkens Ave

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 63041

HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001

E 63041

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 E. Pratt St. ST., 2-4 WARD)

2-FULL NAME Anna A Wonsowicz

(a) RESIDENCE NO. 1820 E. Pratt St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 30 1929

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alexander Wonsowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Amelia Malanowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Amelia Wonsowicz
(Address) 1820 E. Pratt St.

15 Filed Dec 8 1930 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1930 to Dec 7 1930.

that I last saw h[illegible] alive on Dec 7 1930,

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Simple)

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Candace Pondyonis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. J. Rymer M. D.

Dec 9 1930 (Address) 801 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem Dec 9 1930 — DATE OF BURIAL

20 UNDERTAKER John McWeeney & Son Theatre — ADDRESS

TION is very important. See instructions on back of Certificate.

C 8

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63042 / E 63042

CERTIFICATE OF DEATH.

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 East Hamilton ST., 26-12 WARD

2-FULL NAME Lucia Dinatta

(a) RESIDENCE NO. 501 E Hamilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucidio Dinattia

6 DATE OF BIRTH (month, day, and year) May 17, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife .07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Dominico Chiodi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Carucci Ciccini

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Lucido Dinatta

(Address) 501 Hamilton Ave

15 Filed OCT 8 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930 to Nov 30, 1930, that I last saw h[illegible] alive on Nov 30, 1930, and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Heart disease, orig (Tuberculosis? Myocarditis ? Hypertension? Syphilis ? Rheumatic fever)

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocardial failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? BMR 7 Wass. 0-0

What test confirmed diagnosis?

(Signed) John W. Parsons, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 12/8/30 19

20 UNDERTAKER George J Roth Inc

ADDRESS 100 Hoffman

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 63043 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63043

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 935 (Ridgely St.) 21-31 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Mp Fort

(a) RESIDENCE NO. 935 Ridgely ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Fort

6 DATE OF BIRTH (month, day, and year) May 4 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER M Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Maud Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Fort

(Address) 935 Ridgely St

Filed DEC 8 1930 C. HAMPSON JONES, M. D. Registrar

By E.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1930, to Dec. 7, 1930, that I last saw h alive on Dec 6, 1930, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morley Stang, M. D.

Dec 7, 1930 (Address) 729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	12-10 1930

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Holl

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63044

E 63044

CERTIFICATE OF DEATH

1772

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 1-7 Ward)

2-FULL NAME Rozalia Karcz

(a) RESIDENCE NO. 611 S. Kenwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Andrew F. Karcz

6 DATE OF BIRTH (month, day, and year) Sept 18/1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	2	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer At home

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Kendzejewski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Zaworska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Andrew Karcz
(Address) 611 S. Kenwood Ave

15 Filed DEC 8 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Poisoning
Probably Accidental-taken by
mistakefor Aspirin

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

Dec 8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Dec. 10 1930
20 UNDERTAKER	ADDRESS
[signature]	1004 S. Kenwood

Dec

Spec.—1-30—M. & T.—250 Bks.

E 63045

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63045

CERTIFICATE OF DEATH.

161-004

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 20-69 WARD)

2. FULL NAME Frederick Newton, Jr.

(a) RESIDENCE NO. 2613 Lehman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Wh	M	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frederick Newton

11 BIRTHPLACE OF FATHER (city or town) Berlin, Md.

(State or country)

12 MAIDEN NAME OF MOTHER Ethel Ruth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Frederick Sr. Newton

(Address) 2613 Lehman St.

15 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/29, 1930 to 12/6, 1930 that I last saw h[illegible] alive on 12/6, 1930 and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 12/9/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 63046 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63046

161-001

CERTIFICATE OF DEATH.

REGISTERED NO. 20-69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gloria Newton

(a) RESIDENCE NO. 2613 Lehman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	wh	

5a If married, widowed, or divorced HUSBAND of or) WIFE of Fiugle

6 DATE OF BIRTH (month, day, and year) September 7 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick Newton

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Ethel Ruth

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Frederick B. Newton (Address)

15 Filed ... No. ... C. HAMPSON JONES, M. D. Registrar

C 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/24, 1930, to 12/7, 1930, that I last saw h[illegible] alive on 12/7, 1930, and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Marasmus,

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Adams S. Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetary

DATE OF BURIAL 12/9/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63047 + 90 E 63047

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 12-14 ST. Blanche WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Theodore Warner

(a) RESIDENCE NO. Woodman Park Hotel ST., WARD Washington D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Theodore Warner

6 DATE OF BIRTH (month, day, and year) Aug 3 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Marcellus B. Hagenbuch

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Chamberlain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs John H Coyle (Address) 2725 St Paul St

15 Filed 8 1930 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1930, to Dec 6, 1930, that I last saw h[illegible] alive on Dec 6, 1930, and that death occurred, on the date stated above, at 12 m. Night

The CAUSE OF DEATH* was as follows:

Pulmonary Edema and Cardiac Dilatation

(duration) 0 yrs. 0 mos 0 ds. 20 min

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Data

(Signed) Francis W. Gluck, M. D.

12/6/1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Dec 10 1930

20 UNDERTAKER Henry J Jenkins Sons Co — ADDRESS Orchard & Fulton Ave

FOLLOW very important. See INSTRUCTIONS on back of certificate.

E 63048

B50—6,000—2-CB—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63048

90

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH: On dredge No.6 Arundel Corporation off Wagner's Point. ST. 26 - Ward 1

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.)

2-FULL NAME: Stephen S.Cierzniak.

(a) RESIDENCE NO. 4525 Belair Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 37 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, XXXXXXXXXXXXXX (or) HUSBAND of XXXXXXXX: Emma Cierzniak.

6 DATE OF BIRTH (month, day, and year): October 12, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	42	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Marine Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer): Arundel Corporation.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Joseph Cierzniak.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know.

14 Informant: Emma Cierzniak.(wife)

(Address) 4525 Belair Rd.

Filed DEC 8 - 1930 C. Harrison Jones JT Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): December 5, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto A. Reinhardt, M. D. Coroner

12/6 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. — DATE OF BURIAL: Dec 9 1930

20 UNDERTAKER: Stephen J. Fialkowski INC — ADDRESS: 1000 S. Kenwood Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63049

CERTIFICATE OF DEATH.

92 E 63049

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4506 Sorrento Ave ST., 28-71 WARD)

2-FULL NAME Henry J. Hahn Jr

(a) RESIDENCE NO. 4506 Sorrento Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs 3 mos 1 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Tuckett

6 DATE OF BIRTH (month, day, and year): Sept 4 1877

7 AGE: Years 53 | Months 3 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Henry J Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Eliz. Schuppe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant (Address): Fred Hahn 4206 Evergreen Ave

15 Filed DEC 8 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1930, to Dec 5, 1930, that I last saw ~~him~~ alive on Dec 5, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sx.

(Signed) W. G. Kneal, M. D.

12/6, 30 (Address) Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cemetery | DATE OF BURIAL 12/8/30

20 UNDERTAKER: F. B. Hufnagel | ADDRESS 1850 W Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 63050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

REGISTERED NO. E 63050

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 W. Lexington St ST. 14-27 WARD)

2-FULL NAME Johanna Taylor

(a) RESIDENCE NO. 1404 W. Lexington St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Late Otis H. Taylor .

6 DATE OF BIRTH (month, day, and year) August 27, 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
77	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Blumenour

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Frank C. Delcher
(Address) 1512 Hollins St

15 Filed 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1930, to Dec. 5, 1930, that I last saw h alive on Nov. 28, 1930, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. 1 mos. 2 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B. Goodall M. D.

, 19 (Address) 105 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL 12/8/30

20 UNDERTAKER J. Wm. Knuttel

ADDRESS Edmondson Ave

TION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 63051 — REGISTERED NO. E 63051

188-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(a) RESIDENCE NO Do not know. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 40		----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Report. C.D.

(Address)

15 Filed 8 1930 192 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 26, 1930 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the skull and fracture of the pelvis.
B. & O. R. R. Accident.

(duration) yrs. mos. dys.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Candler Building. November 26, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Geo. W. Hemsley Coroner, M. D.

12/8, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross R.R. Co. DATE OF BURIAL 12-8 1930

20 UNDERTAKER Bernard E. Hartman ADDRESS 1 E. Fayette St.

SECTION 8 OF DEATH is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63052

E 63052

CERTIFICATE OF DEATH.

46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 Wilton St ST. 9-18 (WARD)

2-FULL NAME Mary E. McGlushey

(a) RESIDENCE NO. 1324 Wilton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael A. McGlushey

6 DATE OF BIRTH (month, day, and year) Oct. 13, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James Gillen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Michael A. McGlushey (Address) 1324 Wilton St

15 Filed DEC 8 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22-, 1930, to Dec. 6 —, 1930,

that I last saw h[illegible] alive on Dec. 6 —, 1930,

and that death occurred, on the date stated above, at 5 p—m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left ovary

(duration) 4/ yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of about 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby M. D.

12/8/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 9 1930
20 UNDERTAKER Elmer W. Conklin	ADDRESS 9246 Eager St.

THIS IS very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 63053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 63053

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Edmondson Ave ST. 16-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F. McGuiness

(a) RESIDENCE NO. 1013 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Margaret F. McGuiness

6 DATE OF BIRTH (month, day, and year) April 18, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto City Hospital

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Michael McGuiness

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

MAIDEN NAME OF MOTHER: Unknown

BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant: Chas. F. McGuiness

Address: 1013 Edmondson Ave.

Filed DEC 8, 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1930, to Dec 7, 1930, that I last saw h[illegible] alive on Dec 7, 1930 and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Uremia Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) David E. Wilmot, M. D.

Dec 8, 1930 (Address) 626 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec. 10, 1930

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS: 1827 W. North Ave.

E 63054 Dec. 1930—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63054

74-001

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Aged Womens Home

City of BALTIMORE: (No. 1404 W Lexington St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie E Gohlinghorst

(a) RESIDENCE NO. 1404 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	82			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Catherine Sibley
(Address) 1404 W Lexington St

Filed DEC 8 1930 19 C. HAMPTON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1930 to Dec 8 1930
that I last saw h[illegible] alive on Nov. 28, 1930
and that death occurred, on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows: Apoplexy

(duration) yrs. mos. 1 Day

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Edwin B Jones M. D.
19 (Address) 1115 St Paul St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial Dec 10 1930

20 UNDERTAKER George J Smith

ADDRESS 1632 Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—9 30—A. & Co.—250 Bks.

E 63055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Ist E 63055

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No 15 So Caroline St 2nd ...WARD)

2. FULL NAME Serafina D'Fatta

(a) RESIDENCE NO. 15 So Caroline ST. ...WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 30 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carmelo DeFatta

6 DATE OF BIRTH (month, day, and year) Dec 31, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Giovanni Culotta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carmella Di Spirito

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Charles D'Fatta (Address) #15 S Caroline St

15 Filed DEC 8 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6-30

17 I HEREBY CERTIFY, That I attended deceased from September 1, 1930, to December 6, 1930 that I last saw h[illegible] alive on December 6, 1930 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Confusion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

Dec 8, 1930 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 12-9 1930

20 UNDERTAKER George J. Fruth Inc

ADDRESS 1735 Aisquith St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 63056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 E 63056

REGISTERED NO. 2743

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar W. Hildebrand

(a) RESIDENCE NO. 2705 Hamilton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Nita M. Hildebrand

6 DATE OF BIRTH (month, day, and year) May 7 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis C. Hildebrand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Anna M. Eicher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Louis C. Hildebrand (Address) 1705 Hamilton Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7. 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1930, to Dec 7, 1930,

that I last saw h alive on Dec 7, 1930,

and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows:

a Pneumonia

b Lobar

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 12-2-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. W. Hildebrand M. D.

19 (Address) 44 Druid Park Drive

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Dec 9 1930

20 UNDERTAKER Mrs. Mrs. John W. Tuffel & Son

ADDRESS 801 W. Fayette St

HON. H. very important. See instructions on back of certificate.

C. HAMILTON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63057

CERTIFICATE OF DEATH

44 E 63057

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4101 Eierman ST., 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Klausmeyer

(a) RESIDENCE NO. 4101 Eierman ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Klausmeyer

6 DATE OF BIRTH (month, day, and year) July 8th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Amil Klausmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Klausmeyer (Wife)
(Address) 4101 Eierman ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1930, to Dec 6 1930,

that I last saw him alive on Dec 5 1930

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Elmer D Leeman, M. D.

12/6, 1930 (Address) 718 N. Pat Ham

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Dec 9th 1930

20 UNDERTAKER Lilly & Zeller Inc

ADDRESS 408 S. Wolfe St

REGISTRAR JONES

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63058

CERTIFICATE OF DEATH

REGISTERED NO. E 63058

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No. Balto City Hos. ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. [illegible] Noha

(a) RESIDENCE NO. 33 S. Kreeson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Benjamin Noha

6 DATE OF BIRTH (month, day, and year) Aug. 20 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Maria L. Thaja

(Address) 33 S Kreeson

15 Filed ..... 192 ..... Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Acute Angina Pectoris

(duration) yrs. ..... mos. 1/6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.
Coroner

Dec 8, 1930 (Address) 700 Cherry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemt

DATE OF BURIAL Dec 9 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 So Wolfe

Spec.—1-30—M. & T.—250 Bks

E 63059

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63059

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST. 15-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Guy

(a) RESIDENCE NO. 1358 N. Fremont Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) January 1, ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50?	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Acomac Co. (State or country) Va.

PARENTS

10 NAME OF FATHER Fred Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliza Guy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-30

17 I HEREBY CERTIFY, That I attended deceased from 8-14-30, 19 to 12-5-30, 19

that I last saw her alive on 12-5-30, 19

and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, cerebral, + Hemorrhage into cerebrum.

(duration) UNKNOWN. yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? City Hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Paul Padgett, M. D.

12.7.1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Dec 9 1930

20 UNDERTAKER Virginia G. Brooks

ADDRESS 1463 N. Carey St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 63060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 63060

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 S. Port ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie S. Neels

(a) RESIDENCE NO. 822 S. Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Henry W. Neels

6 DATE OF BIRTH (month, day, and year) Dec 17, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Philip Hessenei

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Loudy

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Henry W. Neels (Husband)

(Address) 822 S. Port St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 19 .., to Dec. 7, 19 30, that I last saw h[illegible] alive on Dec. 7. 19 30 and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

about (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Nathan Hirsh, M. D.

19 (Address) 2317 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Dec. 10 1930

20 UNDERTAKER Henry Sander & Sons Inc.

ADDRESS Baltimore St & Breadway

Spec.—1-30—M. & T.—250 Bks

E 6306 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 6306

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 6-9 WARD)

2-FULL NAME Mr. Charles Grill

(a) RESIDENCE NO. 401 N. Ann Street Balt St., Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mar. Grill

6 DATE OF BIRTH (month, day, and year) October 9. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore County

(State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Grill

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Mar. Grill (Wife)

(Address) 401 N. Ann St.

15 Filed ....., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1930, to Dec. 6, 1930, that I last saw h... alive on Dec. 6, 1930, and that death occurred, on the date stated above, at 12-16 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos. 2 da.

CONTRIBUTORY (Secondary) auricular fibrillation & Arteriosclerosis

Total Thyroid (duration) 6 yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Oscar Ehrlbaum, M. D.

, 19 (Address) 409 Cornwall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec. 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St. & Broadway

TION is very important. See instructions on back of certificate.

Spec.—9-30—A. & Co.—250 Bks

E 63062 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63062

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2808 Mosher St. 11-68 WARD)

2-FULL NAME Edwin Elmer Nusz

(a) RESIDENCE No. 2808 Mosher St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in City or town where death occurred yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Nettie V. Nusz

6 DATE OF BIRTH (month, day, and year): March 20 1863

7 AGE: Years 67 Months 8 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 614

(c) Name of employer: B. O R Road

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Oliver Nusz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Indefinite Md

12 MAIDEN NAME OF MOTHER: Cecelia Ingram

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Md

14 Informant: Mrs Nettie V. Nusz
(Address): 2808 Mosher St

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar
By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 7 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 22, 1930, to Dec 7, 1930

that I last saw h~~e~~ alive on Dec 7, 1930

and that death occurred, on the date stated above, at 3 20 m

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Mitral insufficiency

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Hunt Cain M. D.

Dec 7 1930 (Address) 6127 N 40

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Dec 10 1930

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 2178 Pac

TION is very important. See instructions on back of certificates.

Spec.—9-30—A. & Co.—250 Bks.

63063 HEALTH DEPARTMENT—CITY OF BALTIMORE 63063

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 S. Carey St. 21-29 (WARD)

2 FULL NAME Warren. C. B. Gebhart

(a) RESIDENCE NO. 1228 S. Carey St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Carrie Gebhart

6 DATE OF BIRTH (month, day, and year): May 2 1855

7 AGE: Years 74 Months 7 Days 5
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired Baker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS
10 NAME OF FATHER: John Gebhart
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Carrie Gebhart
(Address): 1228 S Carey St

15 Filed 8 1930 Registrar
By C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 7 1930

17 I HEREBY CERTIFY, That I attended deceased from April, 1928, to 12/7/30
that I last saw h alive on 12/7/30
and that death occurred, on the date stated above, at 6.1 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension Duration 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Herbert Davis M. D.
, 19 (Address) 1527 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 9 1930

20 UNDERTAKER: Jos Joerdens — ADDRESS: Don 2173 B.

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 63064 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63064

129

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 Aiken St., 9-18 WARD)

2-FULL NAME Kathleen M. Gahagan

(a) RESIDENCE NO. 1803 Aiken ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-18-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph L. Gahagan

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Barlow

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Joseph L. Gahagan
(Address) 1803 Aiken

Filed 8 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Dec. 7, 1930, that I last saw h[illegible] alive on Dec 6, 1930, and that death occurred, on the date stated above, at 8.10 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Herman E. Dorf, M. D.

, 19 (Address) 112 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	12/10/30 19
20 UNDERTAKER	ADDRESS
[illegible]	1738 Hoff[illegible]

IF NAME is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks W. W. White 2800 St. Paul St. Univ 0175
1100 N. Broadway Univ 0240

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63065 44 E 63065

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 St Paul ST. 12-50 WARD)

2-FULL NAME Adah H. Young

(a) RESIDENCE NO. 2901 St Paul ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Jan 28th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank M. Young
(Address) 2901 St Paul St

15 Filed Dec 8 1930 C. HAMPSON JONES, M. D. Registrar RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 28th, 1930, to Dec 7th, 1930, that I last saw her alive on Dec 6th, 1930 and that death occurred, on the date stated above, at 2 a m m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Gastric)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. W. White M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 12/9/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—9 30—A. & Co.—250 Bks Dr Kinzey 2700 Hartford Rd Belmont 45 41

E 63066 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E63066

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2738 Fenwick Ave 9-46 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Hall

(a) RESIDENCE NO. 2738 Fenwick Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of Edward Hall

6 DATE OF BIRTH (month, day, and ~~year~~) Sept 10th 1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Ringler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs Joseph Waltemeyer
(Address) 2738 Fenwick Ave

Filed 8 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1930

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Dec 8, 1930

that I last saw h alive on Dec 7, 1930

and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows: (1.30)

Carcinoma - rectum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

12 (Signed) Dr J Kinzey M. D.

8, 1930 (Address) 2700 Hartford Rd

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetary — DATE OF BURIAL 12/10/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

C

1-30—M. & T.—100 B—50L

E 63067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 63067

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2417 Annah ST. 16-68 WARD)

2-FULL NAME Lillie A. Wilbur

(a) RESIDENCE NO 2417 Annah ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of R. Holmes Wilbur

6 DATE OF BIRTH (month, day, and year) June 17 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	5	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jas E. Swindell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Elizabeth Lauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant R. Holmes Wilbur
(Address) 2417 Annah St

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar
RKH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
Sudden
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted home
If not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) ..... Coroner, M. D.
(Address) Dec 8 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 12/10/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63068

E 63068

CERTIFICATE OF DEATH

REGISTERED NO. 701-001

1—PLACE OF DEATH: Maryland General Hospital

CITY OF BALTIMORE: (No.) Linden + Madison ST. 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thelma Cornell

(a) RESIDENCE NO. 1772 Covington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Fred Cornell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Helen Pengrade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hospital Records

(Address)

15 Filed 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from November 7, 1930, to December 8, 1930, that I last saw h alive on December 5, 1930 and that death occurred, on the date stated above, at 9:26 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos. 4 ds.?

CONTRIBUTORY (Secondary) Lung Abscess

(duration) yrs. mos. 14 ds.?

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Finding.

(Signed) Robert T. Chenowith M. D.

. 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 12/11/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Blks.

2432 96 E 63069

HEALTH DEPARTMENT—CITY OF BALTIMORE E 63069

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 76-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Bader

(a) RESIDENCE NO. 4620 Ashbury Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth Lee Bader

6 DATE OF BIRTH (month, day and year) 5/6/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night-Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Dairy

(c) Name of employer Western Md Dairy Balto Md

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER J. Lee Bader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lubmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Friends — (Address)

15 Filed Dec 8, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-7-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1930, to Dec 7, 1930, that I last saw him alive on Dec 7, 1930, and that death occurred, on the date stated above, at 6 H0 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Typic ~~ill~~ - bilateral - all Lobes

(duration) yrs. mos 7 4 ds.

CONTRIBUTORY (Secondary) General arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes What test confirmed diagnosis? Post mortem

(Signed) Benj. H. Baker Jr. M. D.

Dec 9, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 12/10/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

C

TION IS VERY IMPORTANT. See instruction on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 63070 ✓ 185 E 63070

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St. Joseph Hospital St. 10-14 Ward)

2-FULL NAME Joseph Hanley

(a) RESIDENCE NO. 1200 Valley St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
male	white	married or widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rose Hanley nee McCabe

6 DATE OF BIRTH (month, day, and year) May 10/1869

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	61	6	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER James Hanley

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth O'Keefe

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Goodmother (Little Sisters
(Address) 1200 Valley St

15 F 1930 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7.30 '92

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Septicemia- Fracture Patella Nov3
Accidentally fell on street.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov13/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Dec 8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Dec 9 1930

20 UNDERTAKER Rita Wiedefeld

ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63071

CERTIFICATE OF DEATH.

E 63071

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Pinecrest Sanatorium (Ward) Govanstown Heights

2-FULL NAME Mary H Briggeman

(a) RESIDENCE NO. 1312 E. Federal ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20 1862

7 AGE: Years 68. Months 10 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dress maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Briggeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Marion L. Bankes 1312 E. Federal St.

15 Filed DEC 9 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1930, to Dec 8, 1930, that I last saw her alive on Dec 8, 1930, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Robert M. Hemmig, M. D.

12/8, 1930 (Address) Catonsville, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney Cemetery — DATE OF BURIAL 12/10 1930

20 UNDERTAKER: Josiah Dyer — ADDRESS 16 W. Lexington St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 63072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x 148 ✓

E 63072

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 1927 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Louise Durall

(a) RESIDENCE NO. 3631 Buena Vista ST., Roley WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard W Durall.

6 DATE OF BIRTH (month, day, and year) sept 15, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	22 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hw.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) gormania, W. Va.

PARENTS

10 NAME OF FATHER George D. gunkens

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Richard W. Durall

(Address) 3631 Buena Vista

15 Filed ....., 19 .... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8/30.

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1930, to Dec 8, 1930, that I last saw h e r alive on Dec 7, 1930 and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

Eclampsia 14 d

(duration) .... yrs. .... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? Caesarian Section

Did an operation precede death? yes no Date of Dec 7, 1930

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. W. Peaper, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ivy Hill Cemetary — DATE OF BURIAL Dec 11 1930

20 UNDERTAKER Elwood R. Fisher — ADDRESS Lund. Md

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63073 E 63073

CERTIFICATE OF DEATH.

X 36-001

REGISTERED NO.

1-PLACE OF DEATH U.S. Marine Hospital Baltimore, Md.

CITY OF BALTIMORE: (No. 12-51 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johnny Jones

(a) RESIDENCE NO. Chance, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deckhand

(b) General nature of Industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer Sch. William H. French

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Jones

11 BIRTHPLACE OF FATHER (city or town) Deals Island, Md.

(State or country)

12 MAIDEN NAME OF MOTHER Becky Jones

13 BIRTHPLACE OF MOTHER (city or town) Chance

(State or country) Md.

14 Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to December 5, 1930, that I last saw him alive on December 5, 1930, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of skin and soft tissues of buttox and perineum

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) [signature] M. D.

12/5, 1930 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Dec. 8, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc. — ADDRESS 125 E. North ave.

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 63074 ✓ E 63074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 E. Preston ST., 8-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David M. Morrison

(a) RESIDENCE NO. 2029 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Edna A. Morrison

6 DATE OF BIRTH (month, day, and year) Feb 26/80

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Woodworker

(b) General nature of industry, business, or establishment in which employed (or employer): 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: Wm Morrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Helen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Edna A. Morrison

(Address) 2029 E. Preston

DEC 8 1930 Filed HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1928, to Dec 6, 1930, that I last saw him alive on Dec 6, 1930, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

(Carcinoma rectal)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of May 18 29

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Geo. Adelberg M. D.

12 7, 1930 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL 12/9 1930

20 UNDERTAKER: Philip Henry

ADDRESS Orleans

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63075

66 E 63075

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2551-Glore ave St. 13th (Ward) 59

2-FULL NAME James Larkins

(a) RESIDENCE NO. 2551-Glore ave St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 2-5-85

7 AGE: Years 46 | Months | Days | IF LESS than 1 day: hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Solo Md

PARENTS

10 NAME OF FATHER: Elijah Larkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Solo Md

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Sarah Della (Address) 2551-Glore ave

15 Filed _____, 19__ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) Dr. H. Schneider, M. D.

12/8, 1930 (Address) 1632 Bolander

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: Dec. 9 1930

20 UNDERTAKER: M. A. Elliott — ADDRESS: 1725 Ashland Ave

EDMUNDSON JONES

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63076 ✓ 46 E 63076

CERTIFICATE OF DEATH.

E 63076

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2829 Remington St. 17-51 WARD)

2-FULL NAME Cordelia Gertrude Brown

(a) RESIDENCE NO. 2829 Remington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married -

5a If married, widowed or divorced ~~HUSBAND of~~ or) WIFE of William Charles Brown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [redacted]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Balto~~ Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Wm Brand
(Address) 2829 Remington ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from October 1, 1930, to Dec. 5, 1930, that I last saw h~~im~~ alive on Dec 5, 1930, and that death occurred, on the date stated above, at 6 P - m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of about 4 yrs ago

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwain, M. D.

, 19 (Address) 31 E Norley Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cemetery	Dec 9 1930
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1725 Oakland ave

DEC 5 1930 HARRISON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

242555
E 63077

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 63077

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-13 WARD)

2-FULL NAME Lula James

(a) RESIDENCE NO. 1809 E Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	unknown

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 19-1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Selon Thornton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Chanty Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL (Address) Woods

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1930, to Dec. 5, 1930, that I last saw h[illegible] alive on Dec. 5, 1930, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

Rheumatic Endocarditis

Mutral Stenosis & Insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Rheumatic heart disease (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical Examination.

(Signed) Benj. M. Baker Jr. M. D.

Dec 5, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bremen Ga DATE OF BURIAL Dec 9, 1930

20 UNDERTAKER Mrs. R. G. Ellicott ADDRESS 1715 Ashland Ave

TION is very important. See instructions on back of Certificate.

Spec.—9-30—A. & Co.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63078

CERTIFICATE OF DEATH.

E 63078

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 331 N. Gilmor St. (St.) (Ward) 19-27

2-FULL NAME Mary Julia Ross

(a) RESIDENCE NO. 331 N. Gilmor St. (Ward)
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Ross

6 DATE OF BIRTH (month, day, and year) 2/1/1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) Unemployed

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Lynchburg Va.

PARENTS

10 NAME OF FATHER Wm. Campbell

11 BIRTHPLACE OF FATHER (city or town) Lynchburg
(State or country) Va.

12 MAIDEN NAME OF MOTHER Anna Turner

13 BIRTHPLACE OF MOTHER (city or town) Lynchburg
(State or country) Va.

14 Informant Mrs. Clara Camm
(Address) 331 N. Gilmore St.

15 Filed DEC 9 1930 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6/30

17

I HEREBY CERTIFY, That I attended deceased from 12/5, 1930, to 12/6, 1930

that I last saw her alive on 12/6, 1930

and that death occurred, on the date stated above, at 8p. m.

The CAUSE OF DEATH* was as follows:

Appoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg, Va.

DATE OF BURIAL 12/9 1930

20 UNDERTAKER Charles G. Cooper

ADDRESS 5 N. Calhoun St.

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

Klein

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63079 ✓ E 63079

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) 6 Caroline & above (St.) E (Ward)

2-FULL NAME Elizabeth Sister Mary Alice O.S.F. 12 Baltimore Md

(a) RESIDENCE (Usual place of abode) St Joseph Hospital St., 12 Ward (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 7-27-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lock Haven Pa

PARENTS

10 NAME OF FATHER John Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lock Haven Pa

12 MAIDEN NAME OF MOTHER Ellen Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lock Haven Pa

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8-30

17 I HEREBY CERTIFY, That I attended deceased from 1-27-30, 19 ..... to 12-8-30, 19 .....

that I last saw h alive on 12-8-30, 19 ..... at 1.55 P.M. and that death occurred, on the date stated above, at 1.55 P.M.

The CAUSE OF DEATH* was as follows:

Scirrhus Cancer Right Breast with Metastasis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Dyspnoea

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1-1-29.

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) M B Hendrick, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Dec 11 1930

20 UNDERTAKER Henry Stocke & Sons Inc

ADDRESS 130 E. Eager St

FOR A VERY important use of this certificate see instructions on page 2

Spec.—1-30—M. & T.—250 Bks

E 63080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 63080

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 331 E. 24th Street (ST.) 12-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas V. Allen

(a) RESIDENCE NO. 331 E-24th Street (ST.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Williamina Mc Allen

6 DATE OF BIRTH (month, day, and year) April 27, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ships Chandler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. W. Allen (Address) 331 E. 24th Street

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7-1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929 to Dec 7, 1930, that I last saw h— alive on Dec 7, 1930, and that death occurred, on the date stated above, at 3^00 A m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio Vascular Renal Disease

Myocardial Degeneration

Senile Cardiosa

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Uremia, Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Thomas Cookman M. D.

, 19 (Address) 1001 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Dec 10 1930

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto St.

HOWARD JONES

C 1930 772

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 63081

74-001

REGISTERED NO. 63081

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 411 W Hamburg ST. 21-31 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Brooks

(a) RESIDENCE NO. 411 W Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) — — 1874

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer Ag Laborer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Charles Also Pal. (Address) 927 Eutaw St.

15. Filed 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7/30

17 I HEREBY CERTIFY, That I attended deceased from 11/26/ 19 30 to 12/7/ 19 30, that I last saw h alive on 12/6/ 19 30, and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Hypertension (duration) about yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Chas Surley M. D.

12/8/ 1930 (Address) 1008 Shark St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion et

DATE OF BURIAL Dec 10 1930

20 UNDERTAKER O'Donnell & Son

ADDRESS Vst & Monroe

H. K. JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 63082

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63082

CERTIFICATE OF DEATH

REGISTERED NO. 74

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 Leadenhall ST., 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lizzie Murry

(a) RESIDENCE NO. 1030 Leadenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Murry

6 DATE OF BIRTH (month, day, and year) Unknown 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Mom Robb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Bertha Mathews

(Address) 1030 Leadenhall St

15 Filed DEC 3 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Dec 7, 1930, that I last saw h— alive on Dec 7, 1930 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis cerebral Hemiplegia

(duration) — yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 1 mos. X ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Howard, M. D.

Dec 8, 1930 (Address) 712 E. Bract. Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL Dec 11 1930

20 UNDERTAKER C. L. Brown & Son

ADDRESS Valley Road

Spec.—1-10-21—M&T—1500 Bks.

E 63033

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63083

CERTIFICATE OF DEATH.

159-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 225 So. High ST. (WARD) 3-5

2-FULL NAME Philip Marano

(a) RESIDENCE NO. 225 So. High ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Dec. 6 - 1930.

7 AGE: Years ..... Months ..... Days 3 hrs. If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Pietro Marano

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Carmella Barrizzo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Angelina Marano 222 S. High

15 Filed DEC 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 8 1930

17 I HEREBY CERTIFY, That I attended deceased from December 6, 1930 to December 8, 1930.

that I last saw him alive on December 7, 1930.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Imp. Forced Child.
Cyst Intestinal Obstruction

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Vehslage M. D.

Dec 9, 1930 (Address) 64 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Dec 9th 1930

UNDERTAKER: Frank V Pepetone

ADDRESS: 2818 E. Baltimore

CAUSE OF DEATH to be filled in plainly, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—9-30—A. & Co.—250 Bks.

E 63084

63084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No 823 Williams ST 22-33 WARD)

2. FULL NAME Katherine A. Williams

(a) RESIDENCE NO 823 William ST. ..... WARD .....
(Casual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas A. Williams

6 DATE OF BIRTH (month, day, and year) June 27 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas McCormick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Healy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Thomas A. Williams
(Address) 823 Williams St

15 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1930

17

I HEREBY CERTIFY. That I attended deceased from April 15th, 1930; to Dec 7, 1930

that I last saw h[illegible] alive on Dec 7th, 1930.

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schwaab M. D.

19 (Address) 1337 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/10 1930

20 UNDERTAKER Fred A. Krause & Son

ADDRESS 703 S. Hanover St

TION is very important. See instructions on back of certificates.

9

Spec.—2-29-28—L. F. S.—500 Bks.

63085

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63085

CERTIFICATE OF DEATH

111-001

1—PLACE OF DEATH 1102 Warner St

CITY OF BALTIMORE (No. 1102 Warner ST. 21-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Richard Wright

(a) RESIDENCE NO. 1102 Warner ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Wright

6 DATE OF BIRTH (month, day, and year): Aug 16, 1873

7 AGE: Years 57 | Months 5 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Phoeba Heales

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Wright

(Address): 1102 Warner

15 Filed DEC 9 1930 .19

C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930 to Dec 1, 1930

that I last saw him alive on Dec 1, 1930

and that death occurred, on the date stated above, at 8.11 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

Toxemia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Stompkins, M. D.

.19 (Address) 501 N. Hamburg St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cherry Lawn Md

DATE OF BURIAL: 12-10 1930

20 UNDERTAKER: Hand Eaton

ADDRESS 916 Orange

1-30—M. & T—100 B—50L

Lessie E Greves

E 63086

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 V E 63086

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1525 Shield ST. 14-20 WARD)

2-FULL NAME Lessie E. Greves

(a) RESIDENCE NO. 1525 Shield ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Jos. Greves

6 DATE OF BIRTH (month, day, and year): 4/15/1905

7 AGE: Years 24 | Months 7 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Married Lady
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D C

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. S.

12 MAIDEN NAME OF MOTHER: Agatha Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Jos Greves
(Address): 1525 Shield

15 Filed DEC 9 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4th 1936

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Phthisis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) [illegible] M. D. Coroner

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnson Cem

DATE OF BURIAL: 12/9 1930

20 UNDERTAKER: Samuel Hunsley

ADDRESS: 2 Biddle

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63087

CERTIFICATE OF DEATH

14-001 E 63087

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 865 Vine ST., 14-7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A. Collins

(a) RESIDENCE NO. 865 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Collins

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) not employed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Henry Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Annie Collins

(Address) 865 Vine

15 Filed Dec 9 1930 C. HAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930 to Dec 6, 1930, that I last saw h~~im~~ alive on Dec 6, 1930 and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. McCard M. D.

12/9, 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Dec. 9, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 S Schroeder St

Spec.—1-30—M. & T.—250 Bks

E 63088 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 7+ 98 E 63088

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 N Arlington ST. 16-26 WARD)

2-FULL NAME Mamie Holland

(a) RESIDENCE No. 628 N Arlington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Arthur Lee Holland

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wilson N C

PARENTS

10 NAME OF FATHER Boston Barbee

11 BIRTHPLACE OF FATHER (city or town) Wilson (State or country) N C

12 MAIDEN NAME OF MOTHER Angeline Wilson

13 BIRTHPLACE OF MOTHER (city or town) Wilson (State or country) N C

14 Informant Arthur L Holland (Address) 628 N Arlington Ave

15 Filed 9 1930 H. HAMPSON JONES, M. D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930, to Dec 7, 1930, that I last saw h[illegible] alive on Dec 7, 1930, and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Dec 11 1930

20 UNDERTAKER Lottie Goss

ADDRESS 1408 Orland Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63039

CERTIFICATE OF DEATH

40 E 63039

1—PLACE OF DEATH

REGISTERED NO. 27-43

CITY OF BALTIMORE: (No. West Balto Gen Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Hermina Engle

(a) RESIDENCE NO. 3105 Mary Ave Hamilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 33 mos. 11 ds. 8 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: Jno Engle

6 DATE OF BIRTH (month, day, and year): Jan 30, 1897

7 AGE: Years 33 | Months 11 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Hagel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Louise Gmeninger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Baltimore Md

14 Informant: Louise B. Hagel

(Address): 3105 Mary Ave

15 Filed Dec 9 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Dec 8, 1930, that I last saw h[er] alive on Dec 8, 1930 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pelvic abscess (S. C.?)

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary): Intestinal Hemorrhage

(duration) yrs. mos. ds. 12 hrs.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 11 / 30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Ashmann, M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	12-10 1930
20 UNDERTAKER: L J Rench	ADDRESS: 1405 Eutaw

Spec.—1-30—M. & T.—250 Bks.

E 63090

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63090

CERTIFICATE OF DEATH.

REGISTERED NO. 185

1-PLACE OF DEATH (Union Memorial Hospital)

CITY OF BALTIMORE: (NO. 33rd & Calvert ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret C. Curran

(a) RESIDENCE NO. 319 Woodland Road ST., Roland Park WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed ~~or divorced~~ ~~HUSBAND OF~~ or WIFE OF widowed Stephen H. Curran

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68(?)	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas O'Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Dorothea A. Curran (Address) daughter

15 Filed DEC 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20th, 1930, to Dec ~~6th~~ 7th, 1930.

that I last saw h[illegible] alive on Dec 6th, 1930,

and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows: Coroner John Morrissey

Fracture Left Hip

Fracture left hip

(duration) yrs. 3 mos 7 ds.

CONTRIBUTORY (Secondary) Chronic bronchitis, bronchopneumonia

(duration) ½ yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis W Steck M. D.

12/7/1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 12-10 1930

20 UNDERTAKER Henry W. Jenkins & Sons Co

ADDRESS Orchard & McCulloh

Spec.—8-16-29—L. F. S.—100 Bks.

E 63091

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 63091

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 W Chase ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ella Kirby

(a) RESIDENCE NO. 17 W Chase ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~ ~~Married~~, Widowed, or ~~Divorced~~, (write the word) Widow

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of Late George A Kirby

6 DATE OF BIRTH (month, day, and year) Oct 3rd 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Hodges

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Josephine Bush

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Maryland

14 Informant N. George Kirby
(Address) 17 W Chase St

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th 1930, to Dec 8th 1930, that I last saw h[er] alive on Dec 7th 1930, and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Senile

Stroke

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C B Thomas Jr, M. D.

12/9, 1930 (Address) 2 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 11 1930
20 UNDERTAKER	ADDRESS
Henry Wenken & Co	Eutaw & Baltimore

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E/G3092

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

#5 E 63092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Cecil

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) JOHNS HOPKINS HOSPITAL ST. (WARD) 7-13

2-FULL NAME John Civish

(a) RESIDENCE NO. 820 N Broadway ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Catherine Civish

6 DATE OF BIRTH (month, day, and year) June 7-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Czecho-Slovakia

PARENTS

10 NAME OF FATHER John Civish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Kazic

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records (Address)

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-30

17 I HEREBY CERTIFY, That I attended deceased from 11-17, 1930, to 12-5, 1930, that I last saw h(er) alive on 12-3, 1930, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal Sarcoma

(duration) 1 yrs. after mos ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 11-26-30

Was there an autopsy? yes

What test confirmed diagnosis? Section of tumor

(Signed) I. S. Trimble M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL 12/12, 1930

20 UNDERTAKER Ed. F. Krause & Son ADDRESS 1128 Mont Royal ave

JOHNS HOPKINS HOSPITAL

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 63093 161-001 E 63093

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1020 W Lanvale ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Smith

(a) RESIDENCE NO. 1028 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 26 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-6-30

7 AGE	Years	Months	Days	If LESS than 1 day, 12 hrs. or min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Smith

11 BIRTHPLACE OF FATHER (city or town) Hampden,
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Hazel Meredith

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mother
(Address)

15 Filed ..., 19... J. Pol Jones, M. D.
Registrar

DEC 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-30

17 I HEREBY CERTIFY, That I attended deceased from 12-6, 1930, to 12-7, 1930, that I last saw h[illegible] alive on 12-6, 1930 and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity ~~+ Inanition~~

12 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M. Alexander Novey M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Disposed of by mother.	19
20 UNDERTAKER	ADDRESS

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63094

CERTIFICATE OF DEATH

90 E 63094

REGISTERED NO. 11-24

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hampton Court apts ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph T Gott

(a) RESIDENCE NO. Hampton Court Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 2 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma B Gott

6 DATE OF BIRTH (month, day, and year) Sept 22 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm H Gott

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Alice Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma B. Gott

(Address) Hampden Court apts

Filed 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 8 30

17 I HEREBY CERTIFY, That I attended deceased from May, 1930, to Dec 8, 1930, that I last saw h[illegible] alive on Dec 8, 1930, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Prostatic senility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) F L Leitch, M. D.

, 19 (Address) Buxton Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. Dec 11 1930

DATE OF BURIAL

20 UNDERTAKER Chas E. Franck

ADDRESS 802 Madison Ave

Spec.—9-30—A & Co.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63095

CERTIFICATE OF DEATH.

100-001

E 63095

REGISTERED NO.

1. PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No) 4137 - Eierman ST. 27 41 WARD

2. FULL NAME Elizabeth H. Rhodes

(a) RESIDENCE NO. 4137 - Eierman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/13/1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Glen Rhodes

11 BIRTHPLACE OF FATHER (city or town) Penna (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Dennon

13 BIRTHPLACE OF MOTHER (city or town) Del. (State or country)

14 Informant Glen Rhodes

(Address) 4137 - Eierman Av.

Filed 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1930, to Dec. 9, 1930

that I last saw her alive on Dec. 9, 1930

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No. Eierman

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel B. Wolfe M. D.

19 (Address) 1334 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

No Autopsy.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanington Del

DATE OF BURIAL 12/11/30

20 UNDERTAKER George D. Pitts Inc

ADDRESS 1700 Hoffman

TION is very important. See instructions on back of certificates.

Spec.—9 30—A. & Co.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63096

CERTIFICATE OF DEATH.

31 REGISTERED NO. E 63096

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No 1906 Aliceanna Street ST. 9-4 WARD)

2 FULL NAME Elenora Andrzejewski or Andrews.

(a) RESIDENCE NO. 1906 Aliceanna Street ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb/15/1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Felix Andrzejewski alex,

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Magdalena Wolter

13 BIRTHPLACE OF MOTHER (city or town) Poland.
(State or country)

14 Informant Magdalena Andrzejewski
(Address) 1906 Aliceanna Street

15 Filed DEC 9 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec/8/1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Dec. 8, 1930, that I last saw h alive on Dec. 6, 1930 and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? C. S & S

(Signed) John J. Conger M. D.

19 (Address) 3627 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery — DATE OF BURIAL Dec 11 1930

20 UNDERTAKER George A. Weber 705 E Ann st — ADDRESS

ATION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

63097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 63097

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 Bentalou ST., 15-68 WARD)

2-FULL NAME Annie R. McFarland

(a) RESIDENCE NO. 1901 Bentalou ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. E. McFarland.

6 DATE OF BIRTH (month, day, and year) May 7 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Dick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas E. McFarland
(Address) 1901 Bentalou

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) ..... yrs. Sudden mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Hamilton Duncan M. D. Coroner

19 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet burying

DATE OF BURIAL Dec 10 1930

20 UNDERTAKER W. W. Poulton

ADDRESS 2237 W. Balto.

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63098

CERTIFICATE OF DEATH.

90 E 63098

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. 16-67 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Carroll.

(a) RESIDENCE NO. 3113 Belmont Avest. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60(?) yrs. mos. ds. How long in U. S., if of foreign birth? 60(?) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced (or) WIFE of HUSBAND of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Companion 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Denis Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann Fleming

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wards R. (Address)

15 Filed 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1930, to Dec 7, 1930, that I last saw her alive on Dec. 7, 1930 and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease, Arteriosclerotic (duration) more than yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency, original (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padgett, M. D.

12-7-1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 12/10 1930

20 UNDERTAKER Harry A. Kuntze, 410 E. Edmondson Ave

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 63099 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63099

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2032 E La Fayette Ave ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul F. Rothschu

(a) RESIDENCE NO. 2032 E La Fayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Martha Rothschu

6 DATE OF BIRTH (month, day, and year) May 15-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Rothschu

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Martha Rothschu

(Address) 2032 E La Fayette Ave

15 Filed ..... 19 ..... S. THEMPSON JONES, M. D. Registrar

9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7-1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 , 1930 , to Dec 7 , 1930

that I last saw him alive on Dec 5 , 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) C W Koury, M. D.

, 19 (Address) 1812 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 12/10/1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans St.

FOR IS very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 63100

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63100

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 S. London St. WARD 11)

2-FULL NAME Mary L. Shipley

(a) RESIDENCE NO. 232 S. London ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lewis L. Shipley

6 DATE OF BIRTH (month, day, and year) Dec 3 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael J. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Veazy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Shipley Son

(Address) 232 S. London Ave

Filed 1930 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1930, to Dec 8, 1930, that I last saw h[illegible] alive on Dec 8, 1930 and that death occurred, on the date stated above, at 7:35 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos 7 ds.

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj C Cole M. D.

, 19 (Address) 1203 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Dec 10-30

20 UNDERTAKER John A. Moran

ADDRESS 3000 E Balto

Spec.—I-12-23—3,&T—500 Blks.

E 63101

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63101

CERTIFICATE OF DEATH

161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3008 E. Monument St. (Ward) 7-11

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Jaecksch

(a) RESIDENCE NO. 3008 E. Monument St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 6, 1930

7 AGE Years — Months — Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (City or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER John G. Jaecksch

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto. md.

12 MAIDEN NAME OF MOTHER Thelma Collins

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto md.

14 Informant (Address) John Jaecksch 3008 E. Monument St.

Filed Dec 9 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1930, to Dec. 9 Dec. 8, 1930,

that I last saw her alive on Dec. 8, 1930

and that death occurred, on the date stated above, at 5. A. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(7 mos.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Isaac F. Ziegler, M. D.

Dec. 9, 1930. (Address) 700 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Dec 9 1930

UNDERTAKER Enoch Pratt & Sons

ADDRESS 1024 Fayette

TION is very important See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 63102

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-0E 63102

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N. Gilmor ST. 14-27 WARD)

2-FULL NAME Harriet Johnson

(a) RESIDENCE NO. 502 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) October 2, 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Saloman Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William E. Johnson

(Address) 322 N. Eutaw St

15 Filed 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8, 30

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1930, to Dec. 8, 1930, that I last saw her alive on Dec 4, 1930, and that death occurred, on the date stated above, at 9:55 a. m.

The CAUSE OF DEATH* was as follows:

L. Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum pending

(Signed) V. E. Taylor M. D.

12/9, 1930 (Address) 522 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnson Cem. DATE OF BURIAL Dec 12 1930

20 UNDERTAKER Joseph A. Lively ADDRESS 709 N Mount st

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 63103 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63103

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 12-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST. WARD)

2-FULL NAME Mr Robert M Rother

(a) RESIDENCE NO. Cambridge Arms Apts 62 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or WIFE of Husband of Mrs Robert M Rother Catherine A. Rother

6 DATE OF BIRTH (month, day, and year) Sept 30, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	81	2	6	

8 OCCUPATION OF DECEASED President

(a) Trade, profession or particular kind of work Banker 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hopkins Place Savings Bank

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Catherine A. Rother

(Address) Cambridge Arms Apartments

15 Filed Dec 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1930, to Dec 6, 1930, that I last saw h[illegible] alive on Dec 6, 1930, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Francis W. Glusk M. D.

12/6/1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Dec. 10 1930

20 UNDERTAKER Joseph D Cook

ADDRESS 1003 West Baltimore S.

TION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 63104

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63104

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE, NO. 3226 Seymour ST., 45-62 WARD)

2-FULL NAME Chas. Thos. Faulkner

(a) RESIDENCE NO 3226 Seymour ST., ... WARD Kokomo Ind.
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie

6 DATE OF BIRTH (month, day, and year) Jan 6 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	5	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Oil Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Wm Faulkner
11 BIRTHPLACE OF FATHER (city or town) (State or country) England
12 MAIDEN NAME OF MOTHER Mary Lloyd.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Annie Faulkner
(Address) 3226 Seymour

15 Filed ..... 1930, 192. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular

(Signed) ..... Coroner, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kokomo, Indiana

DATE OF BURIAL Dec 11, 1930

20 UNDERTAKER John O. Mitchell & Son MHD Mitchell

ADDRESS 1900 Eutaw Place

TION is very important See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 63105

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63105

CERTIFICATE OF DEATH

REGISTERED NO. 26 37 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hos ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Edwards

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50?	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant

(Address)

15 Filed , 192 Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis Acute
Dilation of Heart
Senile Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Unclaimed

What test confirmed diagnosis? Autopsy

(Signed) James M Fenton, M. D.
Coroner

12/1, 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: THE MORGUE.

ADDRESS

Commissioner Health

DEC 9 - 1930

TION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 63106

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63106

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hospital ST., 26-37 WARD)

2-FULL NAME William Lewis

(a) RESIDENCE NO. Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 40				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 0+0

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant

(Address)

15 Filed DEC 9 1930, 192 C. HAMPSON JONES, M. D. Registrar
THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, myocarditis and Embolism of Brain

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James M Faulkner, M. D.
Coroner

12 1, 1930 (Address) 7002 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL
DEC 9 - 1930

20 UNDERTAKER

ADDRESS

Commissioner Health.

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 63107 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63107

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH Provident Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1514 Division ST., 11 WARD)

2-FULL NAME Theresa Camak Posey

(a) RESIDENCE NO. 1100 Madison Ave. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 23; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant

(Address)

Filed 9 1930 19

5267

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29th, 1930, to Dec. 4th, 1930, that I last saw her alive on Dec. 4th, 1930, and that death occurred, on the date stated above, at 9 05 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. George Mc Donald, M. D.

12/4, 1930 (Address) 900 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL D 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

DEC 9 - 1930

PAT WM E. WOOSLEY

Spec.—1-30—M. & T.—250 Bks

(Tase) ✓

E 63108 HEALTH DEPARTMENT—CITY OF BALTIMORE E 63108

CERTIFICATE OF DEATH. 109-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph L. Tase, Hickory Ave

(a) RESIDENCE NO. 3610 Hicory Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
14		10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Tase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Bixby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Martha Tase

(Address) 3610 Hickory Ave

15 Filed DEC 9 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 9-30

17 I HEREBY CERTIFY, That I attended deceased from December 7, 1930, to December 9, 1930, that I last saw him alive on December 9, 1930, and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Tristamillar Abscess

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 8, 1930

Was there an autopsy? No Diagnosis Abscess

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) J. Bayard Marshall, M. D.

12/9 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden

DATE OF BURIAL Dec 11 30

UNDERTAKER H. S. Udell Sons

ADDRESS 3539 Gall Rd

TION is very important See instructions on back of certificate.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 63109

CERTIFICATE OF DEATH

167-001 E 63109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2nd Gen Hosp. ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Olga R. Moore

(a) RESIDENCE NO 1201 Linden Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John

6 DATE OF BIRTH (month, day, and year) Nov 26 - 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46		14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Wm Rehlich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Thilow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Lena Crawford

(Address) 1201 Linden Ave

15 1930 ..., 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:* Suicide Shooting Self

Asphyxia Gas

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1201 Linden Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... Coroner, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL Dec 9th 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 So Paca St

9 TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 63110

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 63110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 Yale Ave ST. 20-71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Schmidt

(a) RESIDENCE NO. 433 Yale Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, ~~or Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Catherine Schmidt

6 DATE OF BIRTH (month, day, and year): May 3 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Clement + Ball

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Robt Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catharine Schmidt

(Address) 433 Yale ave.

15 C. HAMPSON JONES, M. D. Registrar

Dec. 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1930 to Dec 8 1930

that I last saw h— alive on Dec 8 1930

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 0 000 ds.

CONTRIBUTORY (Secondary) Cancer of bladder and

Fever (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? by alveopic treatments

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard S. French M. D.

12/8 1930 (Address) 2379 Arunah Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 12/11/30

20 UNDERTAKER: Geo Lembach

ADDRESS: 525 N Eutaw St

CAUSE OF DEATH—IMPORTANT. See instructions on back of certificates.

9 1930

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 13th DAY July

OF 1965 THE MICROPHOTOGRAPHS APPEARING

HEREIN STARTING WITH #E 59673 - Aug 11 1930 AND

ENDING WITH #E 63110 - DEC 9 1930 ARE AC-

CURATE AND COMPLETE REPRODUCTIONS OF THE

RECORDS OF THE DEPARTMENT OF Health

BUREAU OF Vital Statistics AS DELIVERED

IN THE REGULAR COURSE OF BUSINESS FOR

PHOTOGRAPHING, AND THAT:

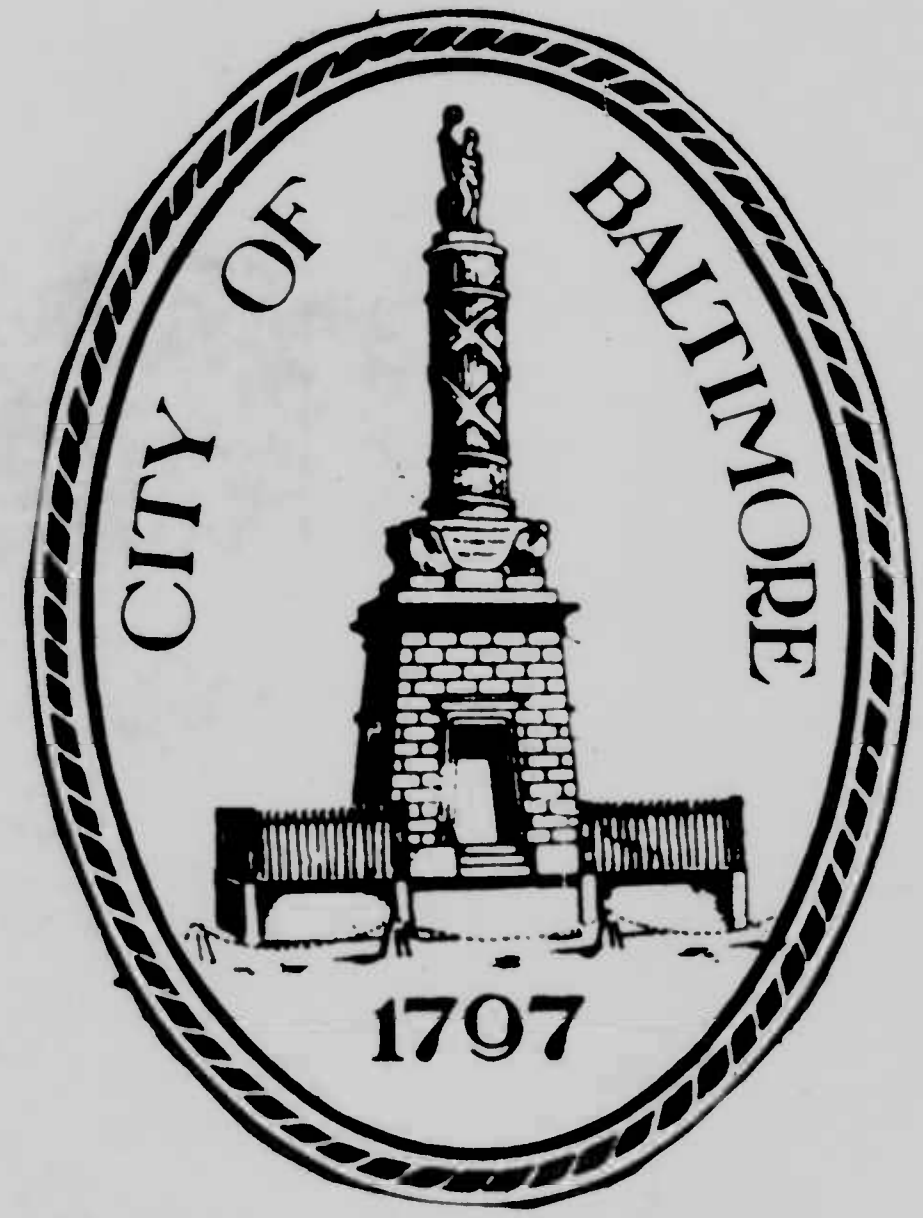
TO THE BEST OF MY KNOWLEIGE THE MICROFILM

MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU

OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC

COPY.

CAMERA OPERATOR: D. McFaul



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